

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04358

CERTIFICATE OF DEATH

04359

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>SOMERSET</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEAL ISLAND 19-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>MAIN ROAD</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First		Middle <b>W.</b>		Last <b>Abbott</b>		4. DATE OF DEATH Month <b>MARCH</b>		Day <b>11</b>		Year <b>1967</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 17-1909</b>		9. AGE (In years lost birth day) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>5</b>		IF UNDER 24 HRS. Days <b>11</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SEA FOOD</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>WILLIAM C. ABBOTT</b>						14. MOTHER'S MAIDEN NAME <b>VIRGINIA WEBSTER</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>MAGGIE ABBOTT DEAL ISLAND MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>2021</b> IMMEDIATE CAUSE (a) <b>Lymphoma</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>3/10/67</b> <b>3/11/67</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>3/10/67</b> to <b>3/11/67</b> , that (I) (we) last saw the deceased alive on <b>3/11/67</b> and that death occurred at <b>2:22</b> M, from causes and on the date stated above.													
22a. SIGNATURE <b>[Signature]</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/11/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>Leroy Webster - Princess Anne</b>						22d. ADDRESS <b>Ind</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/14/67</b>		23c. NAME OF CEMETERY <b>ST. JOHN'S</b>		23d. LOCATION (City or Town) (County) (State) <b>DEAL ISL SOM. MD</b>							
24. FUNERAL DIRECTOR <b>Leroy Webster - Princess Anne</b>						25a. REC'D BY REGISTRAR <b>MAR 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

04326

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04359

CERTIFICATE OF DEATH

04360

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City 23-2 d. STREET ADDRESS R. F. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GRANVILLE L. ADAMS				4. DATE OF DEATH Month Day Year MARCH 10 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1900 9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F. SHERMAN		10b. KIND OF BUSINESS OR INDUSTRY RAY		11. BIRTHPLACE (County & State, or foreign country) WEST NORFOLK VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PERCIVAL S. ADAMSS				14. MOTHER'S MAIDEN NAME MAL (2)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 226-14-7296		17. INFORMANT Mrs G. ADAMS Address Ocean City MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Carcinoma of prostate metastatic DUE TO (b) Carcinoma of prostate DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965, 19 to 2/10, 1967, that (I) (we) lost the deceased on 2/10, 1967, and that death occurred at 4:15 P.M., from causes and on the date stated above.							
22a. SIGNATURE Walter DeWally				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/14/67		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BETHesda Woe. MD	
24. FUNERAL DIRECTOR Anna A. Burboye				ADDRESS Baltimore Md		25a. REC'D BY REGISTRAR MAR 16 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

01366

CERTIFICATE OF DEATH

01366

APR 1 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
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04360

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04361

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>		d. STREET ADDRESS <b>R.F.D. 3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Reginald James Adams</b>		4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1910</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Adams</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Long</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-5595</b>	
17. INFORMANT <b>Mrs Margaret Adams, Pocomoke, Md.</b>		Address <b>R.F.D. 3</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Arteriosclerosis</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Northman</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/26/1967</b> , to <b>3/29/1967</b> , that (I) (we) last saw the deceased alive on <b>3/28/1967</b> and that death occurred at <b>9 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Oswald J. Burton, M.D.</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-31-1967</b>	
23c. NAME OF CEMETERY <b>First Baptist</b>		23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City Wor. Md.</b>	
24. FUNERAL DIRECTOR <b>Robert H. Watson</b> <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

04380

04380

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04361											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution. Reside prior to admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>683 Fitzwater St.</b>						d. STREET ADDRESS <b>683 Fitzwater St.</b>					
3. NAME OF DECEASED (Type or print) <b>Carl F. Bailey</b>						4. DATE OF DEATH <b>March 25, 1967</b>					
5. SEX <b>M.</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1890</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>						11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>					
13. FATHER'S NAME <b>George Bailey</b>						14. MOTHER'S MAIDEN NAME <b>Jennie ?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <b>Gladys Stewart 129 Second St. Salis-Md.</b>					
17. INFORMANT <b>Gladys Stewart</b>						Address <b>129 Second St. Salis-Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Renal Disease</b> 4/42X DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (b) <b>Indefinite</b> (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>25 Dec 1966</b> to <b>25 Mar 67</b> , that (I) (we) last saw the deceased alive on <b>25 Mar 1967</b> , and that death occurred at <b>3:00 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>F. A. Parnell</b>						22b. DATE SIGNED <b>28 Mar 67</b>					
22c. PHYSICIAN'S NAME (Type) <b>F. A. Parnell, M.D.</b>						22d. ADDRESS <b>652 W. MAIN ST., Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/29/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton F. Stewart</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>					
ADDRESS <b>Salis - Md.</b>						DATE <b>MAR 30 1967</b>					

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STATE OF TEXAS

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1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04362											
04364											
Item #4 Film #G307 3722767 bc											
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mardela</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>R D I</i>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mardela</i> d. STREET ADDRESS <i>R D I</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Edwin D. BAILEY</i>						4. DATE OF DEATH <i>March 9 1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 8 1889</i>		9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Boats</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>US</i>		
13. FATHER'S NAME <i>Samuel Bailey</i>						14. MOTHER'S MAIDEN NAME <i>Nancy English</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>213-12-5927</i>		17. INFORMANT <i>Lola Russell Bailey</i>		Address <i>Mardela Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>65</i> , to <i>3/9/67</i> , 19__, that (I) (we) last saw the deceased alive on <i>3/9/67</i> 19__, and that death occurred at <i>5P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>H S Kahlman</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/10/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>H S Kahlman</i>						22d. ADDRESS <i>Sharptown Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/12/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Reston Cem.</i>				23d. LOCATION (City, town or county) (State) <i>Reston Md</i>			
24. FUNERAL DIRECTOR <i>William M. Mowel</i>						ADDRESS <i>Delmar Del.</i>		25. REC'D BY REGISTRAR <i>Mar 14 1967</i>		26. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04363

CERTIFICATE OF DEATH

04365

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b> 232		d. STREET ADDRESS <b>Route #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>ETHEL</b> Last <b>Ball</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 31, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR SEWING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>JAMES G. TAYLOR</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>120-01-2997</b>	
17. INFORMANT <b>MRS. BERNICE TRUITT</b>		Address <b>Snow Hill, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X ruptured abdominal aneurysm</b> DUE TO (b) <b>Generalized atherosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Large fungating carcinoma face, nose, &amp; eye</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3:20</b> , 19 <b>67</b> , to <b>3:21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3:21</b> , 19 <b>67</b> , and that death occurred at <b>7:50</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>H. P. Brille</b>		22b. DATE SIGNED <b>3.27.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. P. Brille</b>		22d. ADDRESS <b>Medical Center</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAR. 25, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cem. VA.</b>	23d. LOCATION (City or town) (County) (State) <b>Salisbury MD</b>
24. FUNERAL DIRECTOR <b>Gerald Grund</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Snow Hill Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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VR A15 (4)  
20 M 1/66

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04364

CERTIFICATE OF DEATH

04366

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Chincoteague</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>110 Jester Street</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lenora Jeanette Birch</b>		4. DATE OF DEATH Month Day Year <b>March 1 1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1893</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>A.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>A.</b>		
13. FATHER'S NAME <b>Ruben Bishop</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Whealton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>180-14-2931</b>		
17. INFORMANT <b>Ansley Birch, Chincoteague, Virginia</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO (b) <b>Thrombophlebitis multiple migratory</b> DUE TO (c) <b>Cause unk.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>466X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Leukocytosis &amp; thrombocytosis post splenectomy 1965</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>02-07-67</b> , 19__, to <b>03-1-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>03-1-67</b> , 19__, and that death occurred at <b>7:30</b> A.M. from causes and on the date stated above.				
22a. SIGNATURE <b>Joseph C. Fitzgerald</b>		22b. DATE SIGNED <b>March 1, 1967</b>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Medical Center</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mechanics Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Chincoteague, Virginia</b>	
24. FUNERAL DIRECTOR <b>Salyer Funeral Home, Chincoteague, Virginia</b>		25a. REC'D BY REGISTRAR <b>MAR 3 1967</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04365

## CERTIFICATE OF DEATH

04367

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>621 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgely</b> 15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>			d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Garrett</b> Middle <b>Black</b> Last <b>Black</b>			4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 21, 1891</b> 76 yrs.		9. AGE (In years last birthday) <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Horney Black</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-20-9110</b>		17. INFORMANT <b>John H. Black</b> Address <b>Ridgely, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary embolism</b> 4500 DUE TO (b) <b>Arteriosclerosis, general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerosis obliterans</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 hours</b>  <b>Years</b>  <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right above-knee amputation; blindness</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>July 1, 1965</b> , to <b>March 14, 1967</b> , that (we) last saw the deceased alive on <b>March 14, 1967</b> , and that death occurred at <b>2:20 P.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>C. H. Winnacott</b>			22b. DATE SIGNED <b>3/14/67</b>		22c. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>
23a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-18-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>
24. FUNERAL DIRECTOR <b>J. E. Bouleis</b>			23d. LOCATION (City or Town) (County) (State) <b>Goldsboro, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1967</b>
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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Home & Away

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Jan. 21, 1891.

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Alfred Huxley

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04366 CERTIFICATE OF DEATH 04368

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>626 Hammond Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AVERY</b> Middle <b>LEE</b> Last <b>BOWDEN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 5, 1897</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>16</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bread Company</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Whaylesville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lemuel Bowden</b>		14. MOTHER'S MAIDEN NAME <b>Annie Parker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-2112</b>	
17. INFORMANT Address <b>Mr. Thomas F. Bowden &amp; Mrs. Sadie Bowden</b> <b>306 Pryor Ave., Salisbury, Md.</b>		(Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> 4201 DUE TO (b) <b>coronary thrombosis</b> DUE TO (c) <b>coronary atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>3 hrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1957</b> to <b>March 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 20, 1967</b> , and that death occurred at <b>9:35 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>March 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L. V. Sohler</b>		22d. ADDRESS <b>303 East Street, Delmar, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 25, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04367

CERTIFICATE OF DEATH

04369

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DELAWARE</b> b. COUNTY <b>Sussex</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lewes</b> 46-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <b>LURANA</b> Middle <b>OWENS</b> Last <b>BRITTINGHAM</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 25, 1884</b>
9. AGE (In years last birthday) <b>83</b> yrs.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Del. Sussex</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID OWENS</b>		14. MOTHER'S MAIDEN NAME <b>LAURA WILLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Mrs MARIA Betts Delmar, Md.</b>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic cardiovascular disease</b> DUE TO (b) <b>Diabetes mellitis</b> DUE TO (c) <b>Diabetic gangrene, foot</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20+ yrs</b> <b>20+ yrs</b> <b>3 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-18, 1967</b> to <b>3-2, 1967</b> that (I) (we) last saw the deceased alive on <b>3-2, 1967</b> , and that death occurred at <b>4:30</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Kent Carney</b>		22b. DATE SIGNED <b>3-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>KENT CARNEY</b>		22d. ADDRESS <b>Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-6-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>GREENWOOD Del.</b>
24. FUNERAL DIRECTOR <b>Hill Funeral Home Salisbury, Md</b> <b>Roman F. Baker</b>		25a. REC'D BY REGISTRAR <b>MAR 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

136240

RECEIVED

136240

MAR 6 1961

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**04368**

**CERTIFICATE OF DEATH**

**04370**

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>			d. STREET ADDRESS <b>Somerset Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George Elmer Brown</b> First Middle Last			4. DATE OF DEATH <b>March 28 1967</b> Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 6, 1891</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Internal Revenue Service</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Somerset Co., Md.</b>	
13. FATHER'S NAME <b>George W. Brown</b>			14. MOTHER'S MAIDEN NAME <b>Ella A. Bounds</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Dorothy Brown, Princess Anne, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung with metastases</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>5 A.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Richard E. Doyle</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard E. Doyle</b>		22d. ADDRESS			
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>	23b. DATE THEREOF <b>3/30/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian</b>	23d. LOCATION (City or Town) (County) (State) <b>Princess Anne, Maryland</b>		
24. FUNERAL DIRECTOR <i>James Heinman</i>		ADDRESS <b>Princess Anne, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 3 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04369

04371

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Wicomico</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b><br>b. COUNTY <b>Wicomico</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. LENGTH OF STAY IN 1b<br><b>64 days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>  |  | e. STREET ADDRESS<br><b>303 E. Locust Street</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Norma</b> Middle <b>Mae</b> Last <b>Bunting</b>   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>16</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 24, 1887</b>                                 |
| 9. AGE (In years lost birthday)<br><b>79 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>22</b> Hours <b>Min.</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Work</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>W. Wheeling, Ohio</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Lewis Steele</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lillian Purdy (nee)</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-52-8179</b>   |   |
| 17. INFORMANT<br><b>Mr. Bernard T. Bunting (Son)</b>   |  | Address<br><b>White Haven, Maryland</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>332X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b><br>DUE TO<br>(b) <b>Cerebral thrombosis</b><br>DUE TO<br>(c) <b>Diabetes mellitus</b>                            |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 days</b><br><b>3 months</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes mellitus</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>67</b> , to <b>3/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>67</b> , and that death occurred at <b>4:35 P.M.</b> , from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>L. V. Maldve</b>  |  | 22b. DATE SIGNED<br><b>3/17/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. V. Maldve, M. D.</b>   |  | 22d. ADDRESS<br><b>Deer's Head Hospital; Salisbury, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>March 20, 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 20 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. H. H. H.</b>   |  |   |   |

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04372

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   | c. LENGTH OF STAY IN b<br><b>17 days</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |   | d. STREET ADDRESS<br><b>407 Walnut St.</b>  |  |
| 3. NAME OF DECEASED<br>First <b>JOHN</b> Middle <b>HENRY</b> Last <b>CAUSEY</b>  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>14</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-9-1882</b>  |
| 9. AGE (In years lost birthday)<br><b>85</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 13. FATHER'S NAME<br><b>-unknown-</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>-unknown-</b>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>214-12-6489</b>  |   | 17. INFORMANT<br><b>Mrs Lillie Causey, Pocomoke City, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br>4200<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Fractured left hip</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>year</b>                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell at home.</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>7:30</b> p.m. <b>2-24-67</b> 19  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Own home</b>   | 20f. (City or town) (County) (State)<br><b>Pocomoke, Worcester, Md.</b>        |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>               |   |   |  |
| ACTUAL SIGNATURE<br><b>Earl L. Royer, M.D.</b>   |   | 22. DATE SIGNED<br><b>March 18, 1967</b>  |  |
| EXAMINER'S NAME (Type)<br><b>409 Camden Ave., Salisbury, Md.</b>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>3-16-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethany Methodist</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pocomoke City Wor. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Watson Funeral Home, Pocomoke, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 21 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                           |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

04371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04373

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>4 hrs.</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Arthur A. Cephas</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>3 26 1967</b>  |  |   |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>colored</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Mar. 4, 1913</b>   |  |
| 9. AGE (In years last birthday)<br><b>54</b> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>lumber</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>                        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 13. FATHER'S NAME<br><b>William Hooper Cephas</b>   |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Roxie Cephas</b>   |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |   |  |
| 16. SOCIAL SECURITY NO.<br><b>216-18-8914</b>   |  |   |  | 17. INFORMANT<br><b>Janie M. Cephas - Selbyville, Dela.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gunshot wound left chest + abdominal</b><br>DUE TO (b) <b>5 hrs</b><br>DUE TO (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Shot 38 cal. pistol</b>                                  |  |   |  |
| 20c. TIME OF INJURY<br>Month Day Year<br><b>11-30-67</b><br>Hour a.m. <b>11</b> 19  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b> |  |
| 20f. (City or town)<br><b>Selbyville</b>  |  |   |  | 20g. (County) (State)<br><b>Dela</b>  |  |   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |
| 22. DATE SIGNED<br><b>7-27-67</b>   |  |   |  | 23. CHIEF MEDICAL EXAMINER<br><b>Ph. A. Insley</b> M.D.   |  |   |  |
| 24. DEPUTY MEDICAL EXAMINER<br><b>Richard T. Watson</b>   |  |   |  | 25. ADDRESS<br><b>Selbyville, Dela.</b>   |  |   |  |
| 26. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 27. DATE THEREOF<br><b>3/30/1967</b>  |  |   |  |
| 28. NAME OF CEMETERY OR CREMATORY<br><b>Showell Cem.</b>  |  |   |  | 29. LOCATION (City or Town) (County) (State)<br><b>Showell, Worcester Md.</b>   |  |   |  |
| 30. REC'D BY REGISTRAR<br><b>MAR 30 1967</b>  |  |   |  | 31. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |

MEDICAL CERTIFICATION

05372

05372

MAY 20 1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04372

CERTIFICATE OF DEATH

04374

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> ✓             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   | c. LENGTH OF STAY IN 1b<br><b>317 days</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>   |   | d. STREET ADDRESS<br><b>606 Hubert Street</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Maude</b> Middle <b>Eva</b> Last <b>Coleman</b>  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>23</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Colored</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Nov. 6, 1900</b>   |
| 9. AGE (In years lost birthday)<br><b>66</b> yrs.  |   | IF UNDER 1 YEAR<br>Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Dorchester Co., Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John Draper Keene</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Chester</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>220-10-6048</b>   |   |
| 17. INFORMANT<br><b>Walter Coleman</b>   |   | Address<br><b>Cambridge, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b><br><b>154X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c) <b>-----</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 years</b><br>Years                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> , 19 <b>66</b> , to <b>3/23</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/23</b> , 19 <b>67</b> , and that death occurred at <b>11:40 A.M.</b> from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>A. C. Mitchell, M.D.</b>  |   | 22b. DATE SIGNED<br><b>3/23/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. C. Mitchell, M.D.</b>  |   | 22d. ADDRESS<br><b>Deer's Head Hospital; Salisbury, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>3/26/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peters</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Meekins Neck Dor. Md.</b>                     |
| 24. FUNERAL DIRECTOR<br><b>Frederick C. Delair</b>   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 27 1967</b>   |   |
| ADDRESS<br><b>Cambridge, Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

ITEM 4

0385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04373

CERTIFICATE OF DEATH

04375

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>330 Camden Avenue</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HAZEL</b> Middle <b>VIRGINIA</b> Last <b>COLLINS</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>17</b> Year <b>1967</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>                      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>September 19, 1909</b>                          |  |
| 9. AGE (in years last birthday)<br><b>57 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>28</b> |  | 11. IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Beautician</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b></b>  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Somerset County, Maryland</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>Robert W. Heath</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mollie Messick</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b></b>  |  |  |  |
| 17. INFORMANT<br><b>Mrs. Clinton Massey (Sister)</b><br><b>Main St., Willards, Maryland</b>  |  |   |  | Address<br><b></b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY + PERITONEAL METASTASIS</b><br>170X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>CARCINOMA - BREAST - RT.</b><br>DUE TO (c) <b></b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos</b><br><b>3 yrs.</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JAN - 1967</b> to <b>17 Mar, 1967</b> , that (I) (we) last saw the deceased alive on <b>17 Mar, 1967</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>H. Gray Reeves MD</b>   |  |   |  | 22b. DATE SIGNED<br><b>March 21 / 1967</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. H. Gray Reeves</b>  |  |   |  | 22d. ADDRESS<br><b>Medical Center, Salisbury, Maryland</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 23b. DATE THEREOF<br><b>March 21, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>    |  |
| 23d. LOCATION (City, town or county) (State)<br><b>Salisbury, Maryland</b>   |  |   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 23 1967</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04374

CERTIFICATE OF DEATH

04376

|  |                                  |  |                                      |  |   |   |   |
|--|----------------------------------|--|--------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b>  |                                  |  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>Wicomico</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |                                  |  |                                      | c. LENGTH OF STAY IN 1b<br><b>1-29-67-38</b>   |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |                                  |  |                                      | d. STREET ADDRESS<br><b>726 Westover Drive</b>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Laura G. Collins</b>  |                                  |  |                                      | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>18</b> Year <b>1967</b>  |   |   |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b> | 7. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH<br><b>9-28-1909</b> | 9. AGE (In years last birthday)<br><b>57</b> yrs.  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>   |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Charles Lee</b>  |                                  |  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>LORNA BROWN</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  |  |                                      | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>HYBERNIA FREEMAN</b> Address <b>124 N. LANE AVE Youngstown Ohio</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>518X Respiratory Insufficiency</b><br>DUE TO (b) <b>Empyema</b><br>DUE TO (c) <b>Broncho pleural Fistulae</b>     |                                  |  |                                      |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Carcinoma of lung - Rt Upper Lobectomy</b>   |                                  |  |                                      |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town)  |                                      | (County)   |   | (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>12:30 P.M.</b> from causes and on the date stated above. |                                  |  |                                      |  |   |   |   |
| 22a. SIGNATURE<br><b>Ronald D. Snyder, M.D.</b>  |                                  |  |                                      | 22b. DATE SIGNED<br><b>3/19/67</b>   |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Ronald D. Snyder, M.D.</b>   |   |
| 22d. ADDRESS   |                                  |  |                                      | 22e. REC'D BY REGISTRAR<br><b>MAR 31 1967</b>  |   | 22f. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>3-22-67</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>SNOW HILL Wicomico Md.</b>                            |   |
| 24. FUNERAL DIRECTOR<br><b>Louisa B. Jolley - Jersey Rd. Rt 2 Salisbury, Md.</b>   |                                  |  |                                      |  |   |   |   |

05820

2520

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04375

CERTIFICATE OF DEATH

04377

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Wicomico</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Willards</b><br>22-1 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |   | d. STREET ADDRESS<br><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ROSA ALICE Cooper</b>   |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>30</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Oct. 17 1897</b> |
| 9. AGE (In years lost birthday)<br><b>74</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>William Taylor</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lavina Lewis</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>XX XX</b>   |   | 16. SOCIAL SECURITY NO.<br><b>212-16-1412</b>   |   |
| 17. INFORMANT<br><b>Lillian Downs</b>  |   | Address<br><b>Willards, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>App 10 hrs</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Residual Myeloma</b>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-30, 1967</b> , to <b>3-30, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-30, 1967</b> , and that death occurred at <b>7:30</b> M, from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>J. Ann B. Cooper</b> M.D.   |   | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Medical Center Salisbury Md</b>   |   | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE THEREOF<br><b>4/2/67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cooper</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Willards Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Lester Whaley</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 4 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |   |   |

55830

5540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04376

CERTIFICATE OF DEATH

04378

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   | c. LENGTH OF STAY IN 1b<br><b>10 Yrs.</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   | d. STREET ADDRESS<br><b>311 N. Blvd.,</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sp. Hill Pr. Sani.</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>ROGER WILSON DISHAROON</b>   |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>2</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Nov. 24, 1897</b>                                    |
| 9. AGE (In years last birthday) yrs.<br><b>69</b>  |   | IF UNDER 1 Year<br>Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Branch Manager</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Life Insurance</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Worester, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Henry W. Disharoon</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ollie Coulbourn</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>229-01-8974</b>   |   |
| 17. INFORMANT<br><b>Mrs. Helen Nock Disharoon sec 2</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1442X</b> IMMEDIATE CAUSE (a) <b>Coronary vascular renal disease</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>3-3</b> , 1966, that (I) (we) last saw the deceased alive on <b>31</b> , 1966, and that death occurred at <b>3:30 P.M.</b> from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>Philip A. Insley</b>  |   | 22b. DATE SIGNED<br><b>3-3-1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Philip A. Insley</b>  |   | 22d. ADDRESS<br><b>Salisbury, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>3-5-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Hill Funeral Home</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Norman F. Baker</b>   |   |
| ADDRESS<br><b>Salisbury, Maryland</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |
| DATE<br><b>MAR 6 1967</b>  |   |   |   |

04376

STATE OF TEXAS

04376

MAR 6 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04377

CERTIFICATE OF DEATH

04379

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Whaleyville</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital, Salisbury, Md.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ethel</b> Middle <b>M.</b> Last <b>Downs</b>   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>8</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 6, 1890</b>                                   |
| 9. AGE (In years last birthday) yrs. <b>76</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Delaware</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Harbison El Lynch</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Hudson</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>XX</b>   |  | 16. SOCIAL SECURITY NO.<br><b>XX</b>  |  |
| 17. INFORMANT<br><b>George Downs</b>   |  | Address<br><b>Whaleyville, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b><br>491X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Multiple rheumatoid arthritis</b><br>DUE TO (c) <b>Years</b> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6/8</b> , 19 <b>60</b> to <b>3/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> , 19 <b>67</b> , and that death occurred at <b>5:05</b> M, from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>L. V. Maldve</b>  |  | 22b. DATE SIGNED<br><b>3/9/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. V. Maldve, M. D.</b>   |  | 22d. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>3/11/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Roxana</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Roxana, Delaware</b> |
| 24. FUNERAL DIRECTOR<br><b>Walter Whaley</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 13 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | 25c. REGISTRAR'S NAME<br><b>Selbyville, Del.</b>  |  |

07520

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|            |  |            |  |             |  |             |  |
|------------|--|------------|--|-------------|--|-------------|--|
| NAME       |  | LAST       |  | FIRST       |  | MIDDLE      |  |
| AGE        |  | SEX        |  | RACE        |  | RELIGION    |  |
| EDUCATION  |  | OCCUPATION |  | MARRIAGE    |  | CHILDREN    |  |
| BIRTH      |  | DEATH      |  | BURIAL      |  | CEMETERY    |  |
| FATHER     |  | MOTHER     |  | GRANDFATHER |  | GRANDMOTHER |  |
| SISTER     |  | BROTHER    |  | AUNT        |  | UNCLE       |  |
| COUSIN     |  | Nephew     |  | Niece       |  | Other       |  |
| Address    |  | City       |  | State       |  | Zip         |  |
| Telephone  |  | Area       |  | Number      |  | Extension   |  |
| Occupation |  | Employer   |  | Address     |  | City        |  |
| Education  |  | School     |  | Teacher     |  | Principal   |  |
| Religion   |  | Church     |  | Pastor      |  | Clergy      |  |
| Marriage   |  | Date       |  | Place       |  | Witnesses   |  |
| Children   |  | Name       |  | Date        |  | Place       |  |
| Other      |  | Name       |  | Date        |  | Place       |  |

RECEIVED  
MAY 1 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2a,b,c & d info. taken from birth cert.

04378

CERTIFICATE OF DEATH

04380

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Worcester</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Berlin</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |  | d. STREET ADDRESS<br><b>Rt. #3, Box 389A</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>BABY DUNCAN</b>  |  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>7</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>3-7-67</b>  |
| 9. AGE (In years lost birthday)<br><b>1</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>25</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Wicomico</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 13. FATHER'S NAME<br><b>Adolphus Douglas DUNCAN</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Audrey Spence</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Emily Spence</b>  |  | Address<br><b>Berlin Md, R.F.D #3-Box 389A</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity</b><br>DUE TO <b>Premature Labor</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Placental Separation</b><br>(c) <b>Placental Separation</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>9:15 A</b> M, from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE<br><b>R. L. Baker M.D.</b>   |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type)  |  | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>3-9-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Chapel</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>NEWARK Wor. Md.</b>                |
| 24. FUNERAL DIRECTOR<br><b>Loretta B. Jolley - Salisbury, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 16 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                       |

9520

85620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04379

CERTIFICATE OF DEATH

04381

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Wicomico</b>           |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. LENGTH OF STAY IN 1b<br><b>22-1</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>607 Monroe Street</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Cecil JOHN Dykes, SR.</b>   |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>March 31 1967</b>  |  |   |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 11, 1911</b>   |  |
| 9. AGE (In years last birthday)<br><b>55</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>10 20</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Worcester County, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Tester</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pump Co.</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Worcester County, Md.</b>               |  |
| 13. FATHER'S NAME<br><b>Charles H. Dykes</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lula V. Davis</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>222-07-6263</b>  |  | 17. INFORMANT Address<br><b>Mrs. Maude Pruitt Dykes (Wife)<br/>607 Monroe Street, Salisbury, Maryland</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>(b) <b>Acute myocardial infarction</b><br>DUE TO<br>(c) <b>Congestive heart failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/23, 1967</b> to <b>3-31, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-31, 1967</b> , and that death occurred at <b>7:45 AM</b> , from causes and on the date stated above.   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>James L. Clifford</b> M.D.   |  |  |  | 22b. DATE SIGNED<br><b>April 1/1967</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. James L. Clifford</b>                                      |  |
| 22d. ADDRESS<br><b>Salisbury, Maryland</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>April 2, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 4 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |

04334

04333

RECORD OF DEATH

UNITED STATES DEPARTMENT OF HEALTH

Worcester, Mass., 1911

Age 65

Married, white, male, born in Massachusetts, United States

2-7-10

Married

White

☐ Male ☐ Female

Age

65

Worcester, Mass.

Sex

Male

Worcester, Mass.

Color

White

Worcester, Mass.

Birth

1846

Worcester, Mass.

Death

1911

Worcester, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

04380

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04382

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Wicomico</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   | c. LENGTH OF STAY IN 1b<br><b>since 12/31/66</b> Rural - Berlin <b>23.2</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Pine Bluff State Hospital</b>  |   | d. STREET ADDRESS<br><b>R # 1, Box 90</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>JOHN JOURNEY ELLIOTT</b>  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>25</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 13, 1897</b>                                  |
| 9. AGE (In years lost birthday)<br><b>69</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waterman</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Somerset Co., Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>James Elliott</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Celia Messick</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>220-16-9691-A</b>   |   |
| 17. INFORMANT<br><b>Records of Pine Bluff Hospital</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/31, 1966</b> , to <b>3/25, 1967</b> , that (I) (we) last saw the deceased alive on <b>3/25, 1967</b> , and that death occurred at <b>2:30</b> M, from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>E.P. Ritchings</b>   |   | 22b. DATE SIGNED<br><b>3/26/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E.P. Ritchings, M.D.</b>   |   | 22d. ADDRESS<br><b>Pine Bluff State Hospital</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>3/28/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNNYRIDGE</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>CRISTIED MD R.F.D</b> |
| 24. FUNERAL DIRECTOR<br><b>Anna A. Burbage Berlin Md</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 30 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Juanes Judge</b>                         |

04380

CERTIFICATE OF DEATH

04380

Form with multiple sections for death certificate, including fields for name, date, and location. The form is partially filled out with handwritten text.

NAME: [Handwritten Name]  
DATE: [Handwritten Date]  
LOCATION: [Handwritten Location]

Additional fields include: SEX, AGE, OCCUPATION, CAUSE OF DEATH, and SIGNATURE.

Vertical text on the right margin, possibly a date stamp or administrative note.

RECEIVED [Handwritten Date]  
[Handwritten Text]



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04381

04383

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>              |  |   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fitzwater St. 683</b>   |  |  |  | d. STREET ADDRESS <b>683 Fitzwater St.</b>   |  |   |   |
| 3. NAME OF DECEASED (Type or print) <b>Charles Fletcher</b>   |  |  |  | 4. DATE OF DEATH <b>March 6 1967</b>   |  |   |   |
| 5. SEX <b>M</b>   |  | 6. COLOR OR RACE <b>C</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>12/26/1895</b>                                  |   |
| 9. AGE (In years last birthday) <b>71</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>19</b>  |  | IF UNDER 24 HRS.<br>Hours <b>6</b> Min. <b>19</b>  |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> |   |
| 13. FATHER'S NAME <b>Unknown</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Emma Fletcher</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <b>Mae Frazier 683 Fitzwater St. Salis-Md.</b>   |  |   |   |
| 17. INFORMANT <b>Mae Frazier 683 Fitzwater St. Salis-Md.</b>  |  |  |  | Address  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus</b> |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>4 yrs</b> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m.<br>p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |   |
| 21. I certify that (I) <b>(I) (Mae Frazier)</b> attended the deceased from <b>1/16/63</b> to <b>3/4/67</b> , that (I) <b>(Mae Frazier)</b> saw the deceased alive on <b>3/4/67</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.   |  |  |  |  |  |   |   |
| 22a. SIGNATURE <b>Ivory U. Sully, Jr., MD</b>   |  |  |  | 22b. DATE SIGNED <b>3/9/67</b>   |  | 22c. PHYSICIAN'S NAME (Type)  |   |
| 22d. ADDRESS <b>P. O. Box 126, Berlin, Md.</b>  |  |  |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town or county) (State)                        |   |
| <b>Burial</b>   |  | <b>3/4/67</b>  |  | <b>Green Arces Cemetery</b>  |  | <b>Salisbury, Maryland</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton F. Stewart</b>  |  |  |  | 25a. REC'D BY REGISTRAR <b>MAR 14 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>                    |   |
| ADDRESS <b>Salis Md.</b>  |  |  |  |  |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04330

CENTRATED TO BEAT

04330

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
JAN 1 1961

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including names and dates.]

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 04382 Item #2d Film #G387 4/6/67 pc  |  | 04384  |  |
| 1. PLACE OF DEATH<br>e. COUNTY <b>Wicomico</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>              |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Nicomico Nursing Home Booth St.</b>   |  | d. STREET ADDRESS<br><b>Booth St. 729 Richmond Ave.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cecie</b> Middle <b>Frazier</b> Last <b>Frazier</b>  |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>22</b> Year <b>1967</b>  |  |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>C.</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 29, 1900</b>          |
| 9. AGE (In years last birthday)<br><b>66</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>66</b> Days <b>66</b>   | IF UNDER 24 HRS.<br>Hours <b>66</b> Min. <b>66</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Hyder Kves</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Hattie Branington</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Vernie Frazier</b>   |  | Address<br><b>No 3 Nockmois Ave.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO <b>Hypertensive C-V-R Disease</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>1143X</b><br>(c) <b>1143X</b><br>(e), stating the underlying cause last. (c) |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)               |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 67</b> to <b>3/22/67</b> , that (I) (we) last saw the deceased alive on <b>3/22/67</b> and that death occurred at <b>3/22/67</b> M, from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><b>William W. Gray</b>   |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>3/24/1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nobo</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Delmar Del.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Clifton S. Stewart</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 30 1967</b>  |  |
| ADDRESS<br><b>Salis</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

48840

48840

1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14  
M  
80  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04383

CERTIFICATE OF DEATH

04385

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |                                  | d. STREET ADDRESS<br><b>111 E. 2nd St.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>SARAH PATE GARDNER</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| First Middle Last  |                                  | DATE OF DEATH<br>Month Day Year<br><b>MARCH 6 19 67</b>   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 4, 1898, 68</b> |
| 9. AGE (In years last birthday) yrs.<br><b>68</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>6</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Parkley, Va.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Edward C. Pate</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Etta Johnson</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Elizabeth Pate</b>   |                                  | Address<br><b>Salisbury Md</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201 Acute antro-lateral myocardial infarction</b><br>DUE TO (b) <b>Coronary atherosclerosis</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Previous lateral myocardial infarction</b>  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-22-</b> , 19 <b>65</b> , to <b>3-6-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-6-</b> 19 <b>67</b> , and that death occurred at <b>6:35</b> A.M., from causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>James L. Clifford M.D.</b>  |                                  | 22b. DATE SIGNED<br><b>3-6-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)   |                                  | 22d. ADDRESS<br><b>Medical Center Salisbury Md</b>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>3-8-67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkley</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkley, Acco, Va.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>J. Richard Johnson</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 10 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |                                  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04384

CERTIFICATE OF DEATH

04386

|   |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b> |  | c. LENGTH OF STAY IN 1b<br><b>23-2</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>Worcester</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ocean City</b>  |  | d. STREET ADDRESS<br><b>GOLF COURSE RD</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>CAROLINE F Gilbert</b>   |  | 4. DATE OF DEATH<br>Month<br><b>March</b><br>Day<br><b>4</b><br>Year<br><b>1967</b>                  |  | 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1882</b>  |  | 9. AGE (In years last birthday)<br><b>84</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months<br><b>8</b><br>Days<br><b>4</b><br>Hours<br><b>19</b><br>Min.       |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>FLORIDA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>unknown</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b> |  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br><b>MR. HAROLD GILBERT</b><br>Address<br><b>Ocean City, MD</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis, Heart Disease</b><br><b>4200</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-28</b> , 19 <b>67</b> , to <b>7-4</b> , 19 <b>67</b> /that (I) (we) last saw the deceased alive on <b>7-4</b> , 19 <b>67</b> , and that death occurred at <b>6:15 P.M.</b> from causes and on the date stated above.   |  | 22a. SIGNATURE<br><b>W. S. Edwards</b>   |  | 22b. DATE SIGNED<br><b>3-7-67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>W. S. Edwards</b>   |  | 22d. ADDRESS<br><b>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b> |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>3/7/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RIVERSIDE</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BERLIN WARE REDEM</b>      |  |
| 24. FUNERAL DIRECTOR<br><b>Anna R. Bumbage</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 10 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | 25c. ADDRESS<br><b>Baltimore</b>   |  | 25d. DATE<br><b>MAR 10 1967</b>   |  | 25e. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | 25f. ADDRESS<br><b>Baltimore</b>   |  | 25g. DATE<br><b>MAR 10 1967</b>   |  | 25h. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                             |  |

01382

CERTIFICATE OF DEATH

01382

Individual Common

01382

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |   |                                |   |  |  |
|---|--|---|---|---|---|--------------------------------|---|--|--|
| 04385   |  |   |   |   | 04387   |                                |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>WICOMICO  |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br>MARYLAND b. COUNTY<br>WICOMICO   |                                |   |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>SALISBURY   |  |   | c. LENGTH OF STAY IN 1b<br>5 mos.   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>SALISBURY   |                                |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>WICOMICO NURSING HOME   |  |   |   |   | d. STREET ADDRESS<br>1014 SMITH ST  |                                |   |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |   |   |                                |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>Eleanor  |  |   | First Middle Last<br>BUNSTEIN Gilmore   |   | 4. DATE OF DEATH<br>March 31 1967   |                                |   |  |  |
| 5. SEX<br>F   |  | 6. COLOR OR RACE<br>W                           |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br>12/11/1896 |   | 9. AGE (In years last birthday)<br>70 yrs.                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>PRACTICAL NURSE  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>RET. NURSE |   | 11. BIRTHPLACE (County & State, or foreign country)<br>NEW YORK STATE   |   |                                | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.      |  |  |
| 13. FATHER'S NAME<br>ALEXANDER GILMORE  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br>ESTHER BUNSTEIN   |                                |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>no   |  |   | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>DAVID J. GILMORE SEE #2  |                                |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary failure<br>334X DUE TO<br>Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis with cerebral involvement 10 yrs.<br>(c) ————  |  |   |   |   |   |                                |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Hip Fracture 10/6/66   |  |   |   |   |   |                                |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <th colspan="5">20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br/>Fall at home Spring Hill Nursing Home</th>   |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Fall at home Spring Hill Nursing Home                                       |                                |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. Oct 10 1966 <th colspan="2">20d. INJURY OCCURRED<br/>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/><th colspan="3">20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br/>Spring Hill Home<th colspan="2">20f. (City or town) (County) (State)<br/>Salisbury Wic. Md.</th></th></th> |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <th colspan="3">20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br/>Spring Hill Home<th colspan="2">20f. (City or town) (County) (State)<br/>Salisbury Wic. Md.</th></th> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>Spring Hill Home <th colspan="2">20f. (City or town) (County) (State)<br/>Salisbury Wic. Md.</th> |                                |   | 20f. (City or town) (County) (State)<br>Salisbury Wic. Md.         |  |
| 21. I certify that (I) (this hospital) attended the deceased from 10/6, 1966, to MAR 31, 1967, that (I) (we) last saw the deceased alive on MAR 31, 1967, and that death occurred at 3:35 PM, from the causes and on the date stated above.   |  |   |   |   |   |                                |   |  |  |
| 22a. SIGNATURE<br>M. D. STERMANIDES   |  |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                                | 22b. DATE SIGNED<br>3/31/67                 |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>M. D. STERMANIDES   |  |   |   |   | 22d. ADDRESS<br>111 DAVIS ST, SALISBURY, MD   |                                |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |   | 23b. DATE THEREOF<br>4/4/1967   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>G.A.R. CEMETERY   |                                |   | 23d. LOCATION (City, town or county) (State)<br>Summit Hill, Penn. |  |
| 24. FUNERAL DIRECTOR<br>Franklin B. Hill, Salisbury   |  |   |   |   | 25a. REC'D BY REGISTRAR<br>APR 4 1967   |                                | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |  |  |

03881

RECEIVED BY MAIL

03881



APR 1987  
NEW YORK STATE  
RECEIVED BY MAIL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04386

CERTIFICATE OF DEATH

04388

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>WICOMICO</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Delmar</b> 22.1 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |  |   | d. STREET ADDRESS<br><b>Route No. 3</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ALEXANDER EDWARD GREEN</b>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>MARCH 18 1967</b>  |  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>Cauc.</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 19, 1896</b>   | 9. AGE (In years last birthday)<br><b>70</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Contractor</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>B.A. Suriname Dutch Guina</b>                |  |
| 13. FATHER'S NAME<br><b>Alexandria Edward Green</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sperling</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>579-03-2519-A</b>   |   | 17. INFORMANT<br>Address<br><b>Mrs. Owen J. Ricker 6529 N. 29th St. Arlington, Va.</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO (b) <b>Embolism</b><br>DUE TO (c) <b>Arthritis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>5722</b>                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>3/10, 1967</b> , to <b>3/18, 1967</b> , that (2) (we) last saw the deceased alive on <b>3/18, 1967</b> , and that death occurred at <b>10 A.M.</b> from causes and on the date stated above.  |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Wm. B. Smith</b> M.D.   |  |   | 22b. DATE SIGNED<br><b>3/18/67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. B. Smith</b>                                    |
| 22d. ADDRESS<br><b>Salisbury, Maryland</b>   |  |   |   |  |  |
| 23a. BURIAL OR CREMATION<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>3/21/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Memorial Pk.</b>  | 23d. LOCATION (City or Town)  | (County)   | (State)<br><b>Falls Church, Virginia</b>   |
| 24. FUNERAL DIRECTOR<br><b>Arlington Funeral Home 3901 N. Fairfax</b>  |  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 22 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04387

CERTIFICATE OF DEATH

04389

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WICOMICO</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SALISBURY</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ocean City</b>   |  |
| c. LENGTH OF STAY in 1b<br><b>1 day</b>   |   | d. STREET ADDRESS<br><b>PACIFIC AVE.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>PENINSULA GEN. HOSPITAL</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>EDWARD RUSSELL GREENE</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>MARCH 24 1967</b>  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1891 SEPT. 29, 1901</b>   |
| 9. AGE (In years lost birthday)<br><b>75</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN GREENE</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>NELLIE BROOKS</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>E.R. GREENE JR.</b>   |   | Address<br><b>OCEAN CITY, MARYLAND</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aneurysm</b><br>451X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b>                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-24</b> , 19 <b>67</b> , to <b>3-24</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>3-24</b> , 19 <b>67</b> , and that death occurred at <b>3-24</b> M, from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Edward K. Carney</b>   |   | 22b. DATE SIGNED<br><b>3-28-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>EDWARD K. CARNEY</b>   |   | 22d. ADDRESS<br><b>MEDICAL CENTER, SALISBURY, MARYLAND</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Type and date)   | 23b. DATE THEREOF<br><b>3/26/1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARSONS CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>SALISBURY, MARYLAND</b>            |
| 24. FUNERAL DIRECTOR<br><b>Dr. C. M. H. 2</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Salisbury, Md.</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   | DATE<br><b>29 1967</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04388

CERTIFICATE OF DEATH

04390

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> b. COUNTY<br><b>Worcester</b>      |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BERLIN</b>                 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |                                  |   | d. STREET ADDRESS<br><b>R.F.D.</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ISAAC THOMAS GRIFFIN</b>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>MARCH 31 19 67</b>   |   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 26 1891</b>  | 9. AGE (In years last birthday)<br><b>75</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CONTRACTOR</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BUILDING</b>  |   | 11. BIRTH PLACE (County & State, or foreign country)<br><b>BERLIN MD</b>  |   |
| 13. FATHER'S NAME<br><b>WILLIAM EDWARD GRIFFIN</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>ROSEANN TIMMONS</b>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>120-12-1819</b>   |   | 17. INFORMANT<br>Address<br><b>MRS. I.T. GRIFFIN, BERLIN, MD R.F.D.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>446X Sepsis</b><br>DUE TO (b) <b>Nephrosclerosis</b><br>DUE TO (c) <b>Arteriosclerotic Heart Disease, Arteriosclerosis Obliterans</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>One month</b>  |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerotic Heart Disease, Arteriosclerosis Obliterans</b>   |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Mar. 25, 19 67 to Mar. 31, 19 67</b> |   |
| 20f. (City or town) (County) (State)<br><b>Mar. 25, 19 67 to Mar. 31, 19 67</b>   |                                  |   |   |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 25, 19 67</b> to <b>Mar. 31, 19 67</b> , that (I) (we) last saw the deceased alive on <b>Mar. 31, 19 67</b> , and that death occurred at <b>4:05 P.M.</b> from causes and on the date stated above.   |                                  |   |   |   |   |
| 22a. SIGNATURE<br><b>Samuel S. Silmore</b>  |                                  |   | 22b. DATE SIGNED  |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Samuel S. Silmore</b>  |
| 22d. ADDRESS  |                                  |   | 22e. M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22f. ADDRESS  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>4/2/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EVERGREEN</b>  |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>BERLIN WOR. MD</b>  |                                  | 23e. REC'D BY REGISTRAR<br><b>APR 4 1967</b>  |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Anna A. Burboze</b>  |                                  | 24a. ADDRESS<br><b>Berlin md</b>  |   | 25. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

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WASHINGTON, D.C. 20535

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04389

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04391

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>DOA Peninsula General Hospital</b>   |   | d. STREET ADDRESS<br><b>623 Ridge Road</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>STANLEY</b> Middle <b>L.</b> Last <b>HALL</b>  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>29</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>W</b>              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-26-1888</b>   |
| 9. AGE (In years lost birthday)<br><b>78</b> yrs.   |   | 10. IE UNDER 1 YEAR Months Days IE UNDER 24 HRS. Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Business Man</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Frank Hall</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ociea Smith</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><b>218-05-3214</b>   |   |
| 17. INFORMANT<br><b>Mrs. Juanita Anderson</b>   |   | Address <b>623 Ridge Road Salisbury, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b><br><br><b>years</b>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |
| 20f. (City or town)   |   | (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE<br><b>Earl L. Royer, M.D.</b>  |   | 22. DATE SIGNED<br><b>March 30, 1967</b>  |   |
| EXAMINER'S NAME (Type)<br><b>409 Camden Ave., Salisbury, Md.</b>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>April 1, 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grotons</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hallwood Va</b>                               |
| 24. FUNERAL DIRECTOR<br><b>Lilliston Funeral Home, Accomac, Virginia</b>  |   | 25a. REC'D BY REGISTRAR<br><b>APR 4 1967</b>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Judge</b>  |   |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04390

04392

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|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ty Zs Kin</b>   |   | c. LENGTH OF STAY IN 1b<br><b>2 yrs</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Samuel Harris</b>   |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>19</b> Year <b>67</b>   |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>C</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-25-1911</b>                                    |
| 9. AGE (In years lost birthday)<br><b>55</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>55</b> Days <b>19</b> Hours <b>19</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Esaw Harris</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Frances Taylor</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>259-40-5113</b>   |   |
| 17. INFORMANT<br><b>Ida Mae G. Kat August, Ga.</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201</b><br>DUE TO (b) <b>Coronary Occlusion</b><br>DUE TO (c) <b>Interval between onset and death</b>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE<br><b>Earl L. Royer, M.D.</b>   |   | 22. DATE SIGNED<br><b>3-20-67</b>   |   |
| EXAMINER'S NAME (Type)<br><b>Earl L. Royer, M.D.</b>   |   | Address (Street, city, town, or county)<br><b>409 Camden Ave., Salisbury, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><b>3/25/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Newbury Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Lincolnton, Ga.</b> |
| 24. FUNERAL DIRECTOR<br><b>C. J. M. Moss, BIV 316, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 27 1967</b>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04391

04393

|   |                                    |   |   |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                    | c. LENGTH OF STAY IN 1b<br><b>397 days</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>  |                                    | d. STREET ADDRESS<br><b>808 Phillips Street</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Hattie</b> Middle <b>Bishop</b> Last <b>Hughes</b>   |                                    | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>19</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Nov. 5, 1900</b> |
| 9. AGE (In years last birthday)<br><b>66 yrs.</b>   |                                    | IF UNDER 1 YEAR<br>Months <b>09</b> Days <b>2</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Dorchester Co., Md.</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John Waters</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Ennalls</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                    | 16. SOCIAL SECURITY NO.<br><b>-----</b>   |   |
| 17. INFORMANT<br><b>Lillie Johnson</b>  |                                    | Address<br><b>Cambridge, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO (b) <b>Chronic pyelonephritis</b><br>DUE TO (c) <b>Diabetes mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>260X</b> |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b><br><b>Years</b><br><b>Years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Anemia</b>  |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>  |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15, 19 66</b> , to <b>Mar. 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 19 19 67</b> , and that death occurred at <b>4:20 P.</b> M. from causes and on the date stated above.   |                                    |   |   |
| 22a. SIGNATURE<br><b>L. V. Maldve, M. D.</b>  |                                    | 22b. DATE SIGNED<br><b>3/20/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. V. Maldve, M. D.</b>  |                                    | 22d. ADDRESS<br><b>Deer's Head Hospital; Salisbury, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 23b. DATE THEREOF<br><b>3/23/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meekins Neck</b>   |                                    | 23d. LOCATION (City or Town) (County) (State)<br><b>Dorchester Co., Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>John C. Delane</b>   |                                    | ADDRESS<br><b>Cambridge, Md.</b>  |   |
| 25. RECEIVED BY REGISTRAR<br><b>MAR 21 1967</b>   |                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

04393

SECTION OF DATA

04393

|                        |  |                   |  |                     |  |                     |  |                   |  |
|------------------------|--|-------------------|--|---------------------|--|---------------------|--|-------------------|--|
| 1. NAME                |  | 2. ADDRESS        |  | 3. CITY             |  | 4. STATE            |  | 5. ZIP            |  |
| 6. PHONE               |  | 7. OCCUPATION     |  | 8. EDUCATION        |  | 9. MARITAL STATUS   |  | 10. AGE           |  |
| 11. SEX                |  | 12. RACE          |  | 13. RELIGION        |  | 14. POLITICAL PARTY |  | 15. VOTING RECORD |  |
| 16. EMPLOYMENT HISTORY |  | 17. CREDIT RECORD |  | 18. CRIMINAL RECORD |  | 19. PSYCH. EVAL.    |  | 20. OTHER         |  |
| 21. SIGNATURE          |  | 22. DATE          |  | 23. WITNESS         |  | 24. OFFICIAL        |  | 25. AGENCY        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b><br>c. LENGTH OF STAY IN 1b<br><b>22-1</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D. #3</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Wicomico</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b><br>d. STREET ADDRESS <b>R.D. #3</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ARCHIE</b> Middle <b>DURAND</b> Last <b>HUMPHREYS</b>   |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>10</b> Year <b>1967</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Dec. 9, 1889</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Farmer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>  | 9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months <b>2</b> Days <b>22</b> Hours <b>Min.</b> |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico Co., Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Charles Humphreys</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Bertha Twilley</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |   | 16. SOCIAL SECURITY NO. <b>219-34-3911</b>  |  |
| 17. INFORMANT <b>Mr. Lee Edwin Humphreys (Son)</b><br><b>R.D. #3, Delmar, Maryland</b>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>unknown</b>  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/9, 1954</b> to <b>death</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>MAR 9</b> 19 <b>67</b> , and that death occurred at <b>2 P M</b> , from the causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><b>Ernest Larmore</b>   |   | 22b. DATE SIGNED<br><b>March 11 / 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Ernest M. Larmore</b>  |   | 22d. ADDRESS<br><b>Grove Street, Delmar, Delaware</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>March 13, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>   | 23d. LOCATION (City, town or county) (State)<br><b>Salisbury, Maryland</b>                                       |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 14 1967</b><br>DATE   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |                                      |  |   |  |  |  |  |  |  |
|---|--|--|--|---|---|--------------------------------------|--|---|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |                                      |  |   |  |  |  |  |  |  |
| 04393   |  |  |  |   | CERTIFICATE OF DEATH  |                                      |  |   |  | 04395  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> |                                      |  |   |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>30 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>East New Market</b> <b>09-2</b>                        |                                      |  |   |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>   |  |  |  |   | d. STREET ADDRESS<br><b>Thompsons town</b>  |                                      |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Paul</b> Middle <b>Jenkins</b> Last <b>Jenkins</b>   |  |  |  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>10</b> Year <b>1967</b>   |                                      |  |   |  |  |  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Colored</b>         |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>6-20-1892</b> |  | 9. AGE (In years lost birthday)<br><b>74</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.                 |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Day Laborer</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Factory</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Dorchester County, Md.</b>  |                                      |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Robert Jenkins</b>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Annie Stanley</b>  |                                      |  |   |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |  | 16. SOCIAL SECURITY NO.<br><b>202-01-5809</b>  |   | 17. INFORMANT<br>Address <b>R.F.D.</b><br><b>Mrs. Grace H. Jenkins, East New Market, Md.</b>  |                                      |  |   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial failure</b><br>DUE TO <b>451 X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aneurysm - thoracic aorta</b><br>DUE TO (c) <b>Hypertensive arteriosclerotic cardiovascular disease</b> |  |  |  |   |   |                                      |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 mins.</b><br><b>years?</b>                   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Broncho pneumonia and chronic emphysema</b>   |  |  |  |   |   |                                      |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |   |   |                                      |  |   |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)   |   |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 8, 1967</b> , to <b>Mar. 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 10, 1967</b> , and that death occurred at <b>8:35 P.M.</b> from causes and on the date stated above.  |  |  |  |   |   |                                      |  |   |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Charles H. Winnacott</b>   |  |  |  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>          |                                      |  | 22b. DATE SIGNED<br><b>3/11/67</b>  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles H. Winnacott, M.D.</b>   |  |  |  |   | 22d. ADDRESS<br><b>Deer's Head State Hospital, Salisbury</b>  |                                      |  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>March 14, 1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Thompsons town Cemetery</b>  |   |                                      | 23d. LOCATION (City or Town) (County) (State) <b>Md.</b><br><b>Near East New Market, Md.</b> |   |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. J. Framptom and Son, Federalsburg, Md.</b>  |  |  |  |   | ADDRESS   |                                      | 25a. REC'D BY REGISTRAR<br><b>MAR 16 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>g Charles Judge</b> |  |  |  |  |  |

01302

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04394

04396

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                               |   |   |  |  |  |  |
|---|-------------------------------|---|---|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>e. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u><br>c. LENGTH OF STAY IN 1b <u>Lifetime</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____ |                               |   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u><br>d. STREET ADDRESS _____<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Mary Anna Jones</u>  |                               |   | <b>4. DATE OF DEATH</b><br>Month <u>3</u> - Day <u>8</u> Year <u>1967</u> |  |  |  |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>7/3/1900</u>  | 9. AGE (In years last birthday) <u>66</u> yrs.   | IF UNDER 1 YEAR<br>Months _____ Days _____<br>IF UNDER 24 HRS.<br>Hours _____ Min. _____ |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>   |   | 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico, Md.</u>   |  |  |  |
| 13. FATHER'S NAME <u>Hase Conway</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Jennie H. Lan Kford</u>   |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>312-44-4649</u>  |   | 17. INFORMANT <u>Charles Jones, Jesterville, Md.</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ischemic Coronary</u><br>DUE TO _____<br>Conditions, if any, which gave rise to immediate cause (b) _____<br>DUE TO _____<br>(c), stating the underlying cause last. _____                      |                               |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 wk.</u>   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                               |   |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) _____  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. _____ p.m. _____ 19 _____  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   |  |  |  |
| 20f. (City or town) _____ (County) _____ (State) _____  |                               | 21. I certify that (I) (this hospital) attended the deceased from <u>2/4</u> 19 <u>67</u> to <u>3/8</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> 19 <u>67</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above. |   |  |  |  |  |
| 22a. SIGNATURE <u>F. A. Beardsley</u>   |                               | 22b. DATE SIGNED <u>3/10/67</u>   |   | 22c. PHYSICIAN'S NAME (Type) <u>F. A. Beardsley</u>  |  |  |  |
| 22d. ADDRESS <u>5215 Gary, Md.</u>  |                               | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>3/11/67</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>   |  |  |  |
| 23d. LOCATION (City, town or county) <u>Jesterville, Md.</u>  |                               | 23e. REC'D BY REGISTRAR <u>14 MAR 1967</u>  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Massie</u>  |                               | 25. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |   |  |  |  |  |

MEDICAL CERTIFICATION

04308

CHIRING AT 24 DEATH

04308

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04395

04397

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>(Rural) Quantico</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |   | d. STREET ADDRESS<br><b>Cherry Walk Road</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDNA</b> Middle <b>TAYLOR</b> Last <b>KOLLE</b>   |   | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>31</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 15, 1891</b>  |
| 9. AGE (In years last birthday)<br><b>76</b> yrs.   |   | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>16</b> Hours <b></b> Min. <b></b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House work</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pennsylvania</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>USA</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Edward Taylor</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Phoebe Gilbert</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>208-12-5263</b>   |   |
| 17. INFORMANT<br><b>Mrs. Joseph G. Scott (Daughter)</b>   |   | Address<br><b>Hebron, Maryland</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>143X</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br>DUE TO<br>(b) <b>Hypertensive cardiovascular disease</b><br>DUE TO<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>10 yrs.</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b></b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/24</b> , 19 <b>67</b> , to <b>3/31/67</b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>3/30</b> , 19 <b>67</b> , and that death occurred at <b>5:15A</b> M, from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>George H. Henning</b>  |   | 22b. DATE SIGNED<br><b>3/31/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. George H. Henning</b>   |   | 22d. ADDRESS<br><b>Salisbury, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>April 3, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Drexel Hill, Pa.</b>                          |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR<br><b>APR 4 1967</b>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04396

04398

|  |  |   |   |   |  |   |  |  |
|--|--|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Wicomico</b> MARYLAND   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b>                 |  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  |   | c. LENGTH OF STAY IN 1b                               |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SALISBURY</b> 22-1 |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |  |   |   | d. STREET ADDRESS<br><b>709 Beauchamp</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Miles STANLEY Levey</b>   |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>MARCH 12, 1967</b>   |  |   |  |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | B. DATE OF BIRTH<br><b>1-3-87</b>   |  |  |
|  |  |   |   | 9. AGE (In years lost birthday)<br><b>80 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>2 9</b>   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Magazines</b> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |
| 13. FATHER'S NAME<br><b>(Unk.)</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>(Unk.)</b>   |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>216-05-9345</b>   |   | 17. INFORMANT Address<br><b>Mr. Ralph B. McIntyre, Sr. (Friend)</b><br><b>Sanford, Virginia 23426</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b><br>DUE TO (b) <b>Hypertensive Heart Disease</b><br>DUE TO (c) <b>Unknown</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>   |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/3/67</b> , to <b>3/12/67</b> , that (I) (we) last saw the deceased alive on <b>3/12/67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.  |  |   |   |   |  |   |  |  |
| 22a. SIGNATURE<br><b>[Signature]</b>   |  |   |   | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>March 12/1967</b>  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>OSWALD BURTON</b>   |  |   |   | 22d. ADDRESS<br><b>Med Center, Salisbury, Md.</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>March 15, 1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>                               |  |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 14 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b><br>c. LENGTH OF STAY IN 1b<br><b>22.1</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Wicomico</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |  | d. STREET ADDRESS<br><b>1024 Pierce Avenue</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>DAVID JOSEPH Logan</b>  |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>25</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>October 26, 1937</b>                                 |
| 9. AGE (In years last birthday)<br><b>29</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>New York</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>David John Logan</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ethel Kathleen St. John</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>240-54-0430</b>  |   |
| 17. INFORMANT<br><b>Mr. David J. Logan (Father)</b><br><b>1024 Pierce Ave., Salisbury, Maryland</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Monocytic Leukemia</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/15/1967</b> to <b>3/25/1967</b> , that (I) (we) last saw the deceased alive on <b>3/25/1967</b> , and that death occurred at <b>7:45 AM</b> , from causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><b>Dr. O. J. Burton</b>  |  | 22b. DATE SIGNED<br><b>March 25/1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. O. J. Burton</b>  |  | 22d. ADDRESS<br><b>Salisbury, Maryland</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>March 28, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |  | 25a. REC'D BY REGISTRAR<br><b>Mar 28 1967</b>  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>  |   |

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STATE OF TEXAS

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John H. \_\_\_\_\_

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Postmaster \_\_\_\_\_

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04398**

Item #8 Film #G387 1/13/67 pc

**CERTIFICATE OF DEATH**

**04400**

|   |  |  |  |   |   |  |  |
|---|--|--|--|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Wicomico</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Wicomico Co</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md 22-1</u><br>d. STREET ADDRESS <u>204 Naylor Ln</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Clara</u> First Middle Last <u>Malone</u>  |  | <b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>31</u> Year <u>1967</u>  |  | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>  |   |  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1887</u><br><u>July 2, 1887</u> <b>9. AGE</b> (In years last birthday) <u>79</u> yrs.  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>  |  | <b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Bald Md</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>—</u>  |   |  |  |
| <b>13. FATHER'S NAME</b> <u>Wm Garnett</u>  |  |  | <b>14. MOTHER'S MARDEN NAME</b> <u>Wood</u>      |   |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u> (If yes give wor or dotes of service)   |  | <b>16. SOCIAL SECURITY NO.</b> <u>—</u>  |  | <b>17. INFORMANT</b> <u>Paul Malone</u> Address <u>2604 Hendon</u>  |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO <u>1201</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular dis</u><br>DUE TO (c) <u>—</u> |  |  |  |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>3 days</u><br><u>years</u>                      |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |  |  |  |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Port II of item 18.)  |  |   |   |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o.m. <u>19</u> p.m.   |  | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | <b>20e. PLACE OF INJURY</b> (Home, form, factory, street, office bldg., etc.)   |   |  |  |
| <b>20f. (City or town)</b> (County) (State)   |  | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 28, 1966</u> , to <u>March 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 30, 1967</u> , and that death occurred at <u>9:15 PM</u> , from causes and on the date stated above. |  |   |   |  |  |
| <b>22a. SIGNATURE</b><br><u>Thomas P. Biebee</u>  |  |  | <b>22b. DATE SIGNED</b><br><u>March 31, 1967</u> |   | <b>22c. PHYSICIAN'S NAME</b> (Type) <u>THOMAS P. BIEBEE</u>                                   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>  |  |  | <b>23b. DATE THEREOF</b> <u>4/4/67</u>           |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Moreland New</u>                                 |  |  |
| <b>23d. LOCATION</b> (City or Town) (County) (State) <u>Balto Md</u>  |  |  | <b>25a. REC'D BY REGISTRAR</b> <u>APR 5 1967</u> |   | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04399

## CERTIFICATE OF DEATH

04401

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Wicomico</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   |
| c. LENGTH OF STAY in 1b<br><b>55 Days</b>   |   | d. STREET ADDRESS<br><b>411 Elizabeth St.</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital, Salisbury, Md.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>Franklin</b> Last <b>Matthews</b><br><b>Monroe/ J. F. Matthews</b>   |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>13</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>March 18, 1888</b>   |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>25</b> Hours <b></b> Min. <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Carpenter</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Builder</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Wicomico County, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Jackson J. Matthews</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sally M. Parsons</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>214-18-4547</b>   |   |
| 17. INFORMANT<br><b>Mr. Franklin W. Matthews (Son)</b>  |   | Address<br><b>411 Elizabeth St., Salisbury, Maryland</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident with hemiplegia</b><br>DUE TO<br>Arteriosclerotic cardiovascular disease<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>4221</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 months</b><br><b>Years</b>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coma since 1/3/67</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b></b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b></b>   |   |
| 20f. (City or town) (County) (State)<br><b></b>   |   | 21. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> , 19 <b>67</b> , to <b>3/13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>67</b> , and that death occurred at <b>7:15 P.M.</b> from causes on and on the date stated above. |   |
| 22a. SIGNATURE<br><b>A. C. Mitchell</b>   |   | 22b. DATE SIGNED<br><b>3/14/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. C. Mitchell, M. D.</b>  |   | 22d. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>March 16, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Park</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 16 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |   |

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|               |  |                |  |               |  |             |  |
|---------------|--|----------------|--|---------------|--|-------------|--|
| NAME          |  | LAST           |  | FIRST         |  | MIDDLE      |  |
| JACKSON       |  | J.             |  | J.            |  | J.          |  |
| AGE           |  | SEX            |  | RACE          |  | RELIGION    |  |
| 35            |  | M              |  | W             |  | C           |  |
| DATE OF BIRTH |  | PLACE OF BIRTH |  | CITY          |  | STATE       |  |
| 1900          |  | NEW YORK       |  | NEW YORK      |  | NEW YORK    |  |
| EDUCATION     |  | SCHOOL         |  | DEGREE        |  | INSTITUTION |  |
| HIGH SCHOOL   |  | NEW YORK       |  | B.S.          |  | COLUMBIA    |  |
| OCCUPATION    |  | EMPLOYER       |  | POSITION      |  | SALARY      |  |
| TEACHER       |  | NEW YORK       |  | TEACHER       |  | \$1000      |  |
| MARRIAGE      |  | DATE           |  | PLACE         |  | OFFICIAL    |  |
| 1920          |  | NEW YORK       |  | NEW YORK      |  | NEW YORK    |  |
| CHILDREN      |  | NAME           |  | DATE OF BIRTH |  | SEX         |  |
| 1             |  | JOHN           |  | 1925          |  | M           |  |
| 2             |  | MARY           |  | 1928          |  | F           |  |
| 3             |  | JOHN           |  | 1930          |  | M           |  |
| 4             |  | MARY           |  | 1932          |  | F           |  |
| 5             |  | JOHN           |  | 1935          |  | M           |  |
| 6             |  | MARY           |  | 1938          |  | F           |  |
| 7             |  | JOHN           |  | 1940          |  | M           |  |
| 8             |  | MARY           |  | 1942          |  | F           |  |
| 9             |  | JOHN           |  | 1945          |  | M           |  |
| 10            |  | MARY           |  | 1948          |  | F           |  |
| 11            |  | JOHN           |  | 1950          |  | M           |  |
| 12            |  | MARY           |  | 1952          |  | F           |  |
| 13            |  | JOHN           |  | 1955          |  | M           |  |
| 14            |  | MARY           |  | 1958          |  | F           |  |
| 15            |  | JOHN           |  | 1960          |  | M           |  |
| 16            |  | MARY           |  | 1962          |  | F           |  |
| 17            |  | JOHN           |  | 1965          |  | M           |  |
| 18            |  | MARY           |  | 1968          |  | F           |  |
| 19            |  | JOHN           |  | 1970          |  | M           |  |
| 20            |  | MARY           |  | 1972          |  | F           |  |
| 21            |  | JOHN           |  | 1975          |  | M           |  |
| 22            |  | MARY           |  | 1978          |  | F           |  |
| 23            |  | JOHN           |  | 1980          |  | M           |  |
| 24            |  | MARY           |  | 1982          |  | F           |  |
| 25            |  | JOHN           |  | 1985          |  | M           |  |
| 26            |  | MARY           |  | 1988          |  | F           |  |
| 27            |  | JOHN           |  | 1990          |  | M           |  |
| 28            |  | MARY           |  | 1992          |  | F           |  |
| 29            |  | JOHN           |  | 1995          |  | M           |  |
| 30            |  | MARY           |  | 1998          |  | F           |  |
| 31            |  | JOHN           |  | 2000          |  | M           |  |
| 32            |  | MARY           |  | 2002          |  | F           |  |
| 33            |  | JOHN           |  | 2005          |  | M           |  |
| 34            |  | MARY           |  | 2008          |  | F           |  |
| 35            |  | JOHN           |  | 2010          |  | M           |  |
| 36            |  | MARY           |  | 2012          |  | F           |  |
| 37            |  | JOHN           |  | 2015          |  | M           |  |
| 38            |  | MARY           |  | 2018          |  | F           |  |
| 39            |  | JOHN           |  | 2020          |  | M           |  |
| 40            |  | MARY           |  | 2022          |  | F           |  |
| 41            |  | JOHN           |  | 2025          |  | M           |  |
| 42            |  | MARY           |  | 2028          |  | F           |  |
| 43            |  | JOHN           |  | 2030          |  | M           |  |
| 44            |  | MARY           |  | 2032          |  | F           |  |
| 45            |  | JOHN           |  | 2035          |  | M           |  |
| 46            |  | MARY           |  | 2038          |  | F           |  |
| 47            |  | JOHN           |  | 2040          |  | M           |  |
| 48            |  | MARY           |  | 2042          |  | F           |  |
| 49            |  | JOHN           |  | 2045          |  | M           |  |
| 50            |  | MARY           |  | 2048          |  | F           |  |
| 51            |  | JOHN           |  | 2050          |  | M           |  |
| 52            |  | MARY           |  | 2052          |  | F           |  |
| 53            |  | JOHN           |  | 2055          |  | M           |  |
| 54            |  | MARY           |  | 2058          |  | F           |  |
| 55            |  | JOHN           |  | 2060          |  | M           |  |
| 56            |  | MARY           |  | 2062          |  | F           |  |
| 57            |  | JOHN           |  | 2065          |  | M           |  |
| 58            |  | MARY           |  | 2068          |  | F           |  |
| 59            |  | JOHN           |  | 2070          |  | M           |  |
| 60            |  | MARY           |  | 2072          |  | F           |  |
| 61            |  | JOHN           |  | 2075          |  | M           |  |
| 62            |  | MARY           |  | 2078          |  | F           |  |
| 63            |  | JOHN           |  | 2080          |  | M           |  |
| 64            |  | MARY           |  | 2082          |  | F           |  |
| 65            |  | JOHN           |  | 2085          |  | M           |  |
| 66            |  | MARY           |  | 2088          |  | F           |  |
| 67            |  | JOHN           |  | 2090          |  | M           |  |
| 68            |  | MARY           |  | 2092          |  | F           |  |
| 69            |  | JOHN           |  | 2095          |  | M           |  |
| 70            |  | MARY           |  | 2098          |  | F           |  |
| 71            |  | JOHN           |  | 2100          |  | M           |  |
| 72            |  | MARY           |  | 2102          |  | F           |  |
| 73            |  | JOHN           |  | 2105          |  | M           |  |
| 74            |  | MARY           |  | 2108          |  | F           |  |
| 75            |  | JOHN           |  | 2110          |  | M           |  |
| 76            |  | MARY           |  | 2112          |  | F           |  |
| 77            |  | JOHN           |  | 2115          |  | M           |  |
| 78            |  | MARY           |  | 2118          |  | F           |  |
| 79            |  | JOHN           |  | 2120          |  | M           |  |
| 80            |  | MARY           |  | 2122          |  | F           |  |
| 81            |  | JOHN           |  | 2125          |  | M           |  |
| 82            |  | MARY           |  | 2128          |  | F           |  |
| 83            |  | JOHN           |  | 2130          |  | M           |  |
| 84            |  | MARY           |  | 2132          |  | F           |  |
| 85            |  | JOHN           |  | 2135          |  | M           |  |
| 86            |  | MARY           |  | 2138          |  | F           |  |
| 87            |  | JOHN           |  | 2140          |  | M           |  |
| 88            |  | MARY           |  | 2142          |  | F           |  |
| 89            |  | JOHN           |  | 2145          |  | M           |  |
| 90            |  | MARY           |  | 2148          |  | F           |  |
| 91            |  | JOHN           |  | 2150          |  | M           |  |
| 92            |  | MARY           |  | 2152          |  | F           |  |
| 93            |  | JOHN           |  | 2155          |  | M           |  |
| 94            |  | MARY           |  | 2158          |  | F           |  |
| 95            |  | JOHN           |  | 2160          |  | M           |  |
| 96            |  | MARY           |  | 2162          |  | F           |  |
| 97            |  | JOHN           |  | 2165          |  | M           |  |
| 98            |  | MARY           |  | 2168          |  | F           |  |
| 99            |  | JOHN           |  | 2170          |  | M           |  |
| 100           |  | MARY           |  | 2172          |  | F           |  |

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04400

## CERTIFICATE OF DEATH

04402

|  |                                  |   |                                     |
|--|----------------------------------|---|-------------------------------------|
| <b>1. PLACE OF DEATH.</b><br>a. COUNTY<br><u>Wicomico</u> MARYLAND   |                                  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>          |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Salisbury</u>   |                                  | c. LENGTH OF STAY IN lb<br><u>30 Years</u>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Peninsula General Hospital</u>  |                                  | d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |                                     |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>Clifford</u> <u>MCNEAL</u>   |                                  | <b>4. DATE OF DEATH</b> Month Day Year<br><u>March 13</u> 19 <u>67</u>  |                                     |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/4/1892</u> |
| 9. AGE (In years last birthday)<br><u>75</u> yrs.  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u>   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Georgia</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U S A</u>  |                                     |
| 13. FATHER'S NAME<br><u>Juliah Frances</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Anna Dixon</u>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |                                     |
| 17. INFORMANT Address<br><u>Bishop M.T. McNeal, Princess Anne, Md</u>  |                                  |   |                                     |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thromboses (2)</u><br>(b) <u>Hypertensive Cardio Vascular Disease</u><br>(c) <u>Unknown</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes Mellitus. Uremia Chronic Glomerulosclerosis</u>   |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>28 + 1 days</u>  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/1/67</u> , 19 <u>67</u> to <u>3/13/67</u> , that (I) (we) last saw the deceased alive on <u>3/12/1967</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.   |                                  |   |                                     |
| 22a. SIGNATURE<br><u>[Signature]</u>   |                                  | 22b. DATE SIGNED<br><u>3/13/67</u>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><u>[Signature]</u>   |                                  | 22d. ADDRESS<br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>3/19/67</u>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Isreal Memorial</u>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Lottels Maryland</u>  |                                     |
| 24. FUNERAL DIRECTOR<br><u>William H. James Jr. Princess Anne, Md</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>MAR 21 1967</u>   |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |                                  | 25c. REGISTRAR'S NAME<br><u>Charles Judge</u>   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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04401

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04403

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>e. COUNTY <b>Wicomico</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>              |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  |   |  | c. LENGTH OF STAY IN b<br><b>3 hrs.</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>115 Kendall st.</b>   |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b> <b>22-1</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Billie</b> Middle <b>Ann</b> Last <b>Messick</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>13</b> Year <b>19 67</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 14, 1934</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>32</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>32</b> Days <b>32</b> Hours <b>32</b> Min.                               |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gas Company</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>William Messick</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Annabelle MacLain</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>214-32-0521</b>   |  |  |  |
| 17. INFORMANT<br><b>Mrs. Wm. E. Messick</b>  |  |   |  | Address <b>See #2</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute tracheo bronchitis</b><br><b>500X</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Sarcoidosis of mediastinum</b><br>(c) <b>due to</b><br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Interval between onset and death</b><br><b>hours</b><br><b>year</b> |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Earl L. Royer</b> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type)   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  | DATE SIGNED<br><b>3-14-67</b>  |  |  |  |
| Address (Street, city, town, or county)  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>3/16/1967</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Salisbury, Maryland</b> |  |
| 23. FUNERAL DIRECTOR<br><b>George C. Hays</b><br>ADDRESS<br><b>Salisbury, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>MAR 16 1967</b><br>DATE  |  |  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| 04402   |  | Item #1d File #5307-47-67 pc                        |   |   |  | 04404  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Wicomico</i>   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>MARYLAND</i><br>b. COUNTY<br><i>Wicomico</i> |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Salisbury</i>  |  |   | c. LENGTH OF STAY IN 1b<br><i>2 yrs</i>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Salisbury</i>   |  |  | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>614 W. Isabella Street</i>   |  |   |   |   | d. STREET ADDRESS<br><i>705 W. Isabella St.</i>  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Frank</i> Middle <i>Oliver</i> Last <i>Milbourne</i>  |  |   |   |   | 4. DATE OF DEATH<br>Month <i>3</i> Day <i>16</i> Year <i>1967</i>  |  |  |   |  |
| 5. SEX<br><i>M</i>  |  | 6. COLOR OR RACE<br><i>AA</i>                       |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>4-16-1885</i>               |  | 9. AGE (In years last birthday) <i>81</i> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>LABORER</i> |   | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Accomac Co. VA</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>      |  |   |  |
| 13. FATHER'S NAME<br><i>Julius Milbourne</i>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><i>SARAH Copes</i>   |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.                             |   | 17. INFORMANT<br><i>Phyllis Milbourne</i>   |  | Address<br><i>705 W. Isabella St. Salisbury MD</i> |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4221 Regenerative Heart Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |   |   |   |  |  |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yrs Indefinite</i>   |  |   |   |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <i>19</i>  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2 Jan</i> , 19 <i>67</i> , to <i>16 Mar</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>16 Mar</i> , 19 <i>67</i> , and that death occurred at <i>12:00</i> M, from the causes and on the date stated above.  |  |   |   |   |  |  |  |   |  |
| 22a. SIGNATURE<br><i>F. A. Parnell</i>  |  |   |   |   | 22b. DATE SIGNED<br><i>21 Mar 67</i>   |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>F. A. Parnell, MD</i>  |  |   |   |   | 22d. ADDRESS<br><i>652 W. Main St, Salisbury, Md.</i>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |   | 23b. DATE THEREOF<br><i>3-19-67</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>First Baptist</i>   |  | 23d. LOCATION (City, town or county) (State)<br><i>Mappsville, Va.</i> |   |  |
| 24. FUNERAL DIRECTOR<br><i>Leota L. Gally</i>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br><i>Charles Judge</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                     |   |  |
| ADDRESS<br><i>Jersey Rd. #12 Salisbury, Md.</i>   |  |   |   |   | DATE<br><i>MAR 31 1967</i>   |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04403

## CERTIFICATE OF DEATH

04405

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Wicomico</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. LENGTH OF STAY IN 1b<br><b>since 3/6/67</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-Salisbury</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Pine Bluff State Hospital</b>   |  |   | d. STREET ADDRESS<br><b>RFD # 4</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>WARREN DAVID NAIRNE</b>   |  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>24</b> Year <b>1967</b>   |  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>C</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 29, 1911</b>   |  | 9. AGE (In years lost birthday)<br><b>55</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Wicomico Co., Md.</b>                            |   |
| 13. FATHER'S NAME<br><b>Arthur Nairne</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ida Black</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>215-36-0321</b>   |   | 17. INFORMANT<br><b>Records of Pine Bluff Hospital</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>002.1</b> IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO (c) _____ |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/6/</b> , 19 <b>67</b> , to <b>3/24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> , 19 <b>67</b> , and that death occurred at <b>11:03 pm</b> from causes and on the date stated above.                                  |  |   |   |  |   |
| 22a. SIGNATURE<br><b>E.P. Ritchings</b>  |  |   | 22b. DATE SIGNED<br><b>3/25/67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>E.P. Ritchings, M.D.</b>                                       |
| 22d. ADDRESS<br><b>Pine Bluff State Hospital</b>   |  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>3/30/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Fruitland Md.</b>                                      |   |
| 24. FUNERAL DIRECTOR<br><b>Chas. Stewart Salis - Md.</b>   |  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 30 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |

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CERTIFICATE OF DEATH

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
COUNTY OF LOS ANGELES  
CITY OF LOS ANGELES  
I, \_\_\_\_\_, Registrar of the County of Los Angeles, do hereby certify that \_\_\_\_\_ was born on \_\_\_\_\_ at \_\_\_\_\_, California, and died on \_\_\_\_\_ at \_\_\_\_\_, California, of \_\_\_\_\_.

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04404

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04406

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Wicomico</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>DOA Peninsula General Hospital</b>  |   | d. STREET ADDRESS<br><b>408 Patrick Ave.</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Morris</b> Middle <b>NUTTER</b> Last <b>NUTTER</b>  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>29</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>AA</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 15, 1904</b>   |
| 9. AGE (In years last birthday)<br><b>62</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>LABORER</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Mt. Vernon</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Jim Nutter</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Bloodworth</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>220-10981</b>   |   |
| 17. INFORMANT<br><b>DORA NUTTER</b>  |   | Address<br><b>408 Patrick Ave. Salisbury, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b><br>DUE TO<br>(c) <b>years</b>   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE<br><b>Earl L. Royer, M.D.</b>   |   | 22. DATE SIGNED<br><b>March 30, 1967</b>  |   |
| EXAMINER'S NAME (Type)<br><b>409 Camden Ave., Salisbury, Md.</b>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>4-3-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul's Methodist</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Mt. Vernon Somerset Md.</b>                   |
| 24. FUNERAL DIRECTOR<br><b>Jolley Funeral Home, Salisbury, Md.</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

04108

04108

MAY 12 1964

*[Handwritten signature]*



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04405

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04407

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |   | d. STREET ADDRESS<br><b>Route # 1 Box 185</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Melvin Leroy Parsons</b>   |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>18</b> Year <b>67</b>   |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-17-20</b>               |
| 9. AGE (In years lost birthday)<br><b>46</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)<br><b>Repair</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Body Shop</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Unk</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unk</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>   |   | 16. SOCIAL SECURITY NO.<br><b>Family</b>  |   |
| 17. INFORMANT<br><b>Family</b>   |   | Address<br><b>Same</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)              |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE<br><b>Earl L. Royer, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)<br><b>409 Camden Ave. Salisbury, Md.</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE THEREOF<br><b>3/22/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto Nat'l Cem</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>McCully F H 237 Patapsco Ave 21225</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 23 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>   |   | 22. DATE SIGNED<br><b>3-18-67</b>   |   |

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04406

## CERTIFICATE OF DEATH

04408

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b>   |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MD.</b>   |  | b. COUNTY<br><b>Wicomico</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. LENGTH OF STAY IN 1b<br><b>13 Days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Nanticoke</b>  |  | <b>22-1</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |  |  |  | d. STREET ADDRESS   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mimie Lee</b>  |  | First Middle Last<br><b>Lee Perry</b>  |  | 4. DATE OF DEATH<br><b>March 16 1967</b>  |  | Month Day Year  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6/10/1896</b>  |  |
| 9. AGE (In years last birthday)<br><b>70</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Wicomico - Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-07-6308</b>  |  | 17. INFORMANT<br><b>Ralph Jones, Nanticoke, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Gastro Enteritis</b><br>DUE TO (b) <b>metastatic xeroderma</b><br>DUE TO (c) <b>adenocarcinoma vagina</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>1 week</b><br><b>1 yr</b>                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> , 19 <b>67</b> , to <b>3/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>67</b> , and that death occurred at <b>7:10</b> M, from causes and on the date stated above   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Osborne Chris Kusew</b>  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>3/16/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Salisbury, Md.</b>   |  |  |  | 22d. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>buried</b>  |  | 23b. DATE THEREOF<br><b>3/18/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nanticoke Com. Nanticoke, Md.</b>  |  | 23d. LOCATION (City or Town) (County) (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>C Messing, BIVILLE, Md.</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 21 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

04408

CERTIFICATE OF DEATH

04408

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| Name of Deceased       |  | Date of Birth          |  |
| Sex                    |  | Race                   |  |
| Marital Status         |  | Place of Birth         |  |
| Occupation             |  | Cause of Death         |  |
| Time of Death          |  | Place of Death         |  |
| Signature of Physician |  | Signature of Registrar |  |
| Date of Death          |  | Date of Registration   |  |

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF VITAL RECORDS, BUREAU OF VITAL RECORDS, WASHINGTON, D.C. 20540.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04407

## CERTIFICATE OF DEATH

04409

|   |  |                                      |  |  |   |  |   |   |  |
|---|--|--------------------------------------|--|--|---|--|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D. #1</b>  |  |                                      |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b><br>d. STREET ADDRESS <b>R.D. #1</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <b>MAMIE</b> Middle <b>VIRGINIA</b> Last <b>PHILLIPS</b>   |  |                                      |  | <b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>24</b> Year <b>19 67</b>   |   |  |   |   |  |
| <b>5. SEX</b> <b>Female</b>   |  | <b>6. COLOR OR RACE</b> <b>White</b> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |   | <b>8. DATE OF BIRTH</b> <b>September 2, 1889</b>   |   | <b>9. AGE</b> (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>22</b> Hours <b>Min.</b> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House work</b>  |  |                                      |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Worcester County, Maryland</b>     |   | <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>  |  |
| <b>13. FATHER'S NAME</b> <b>Alfred F. Pusey</b>   |  |                                      |  | <b>14. MOTHER'S MAIDEN NAME</b> <b>Nancy Ellen Smullen</b>   |   |  |   |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |                                      |  | <b>16. SOCIAL SECURITY NO.</b>   |   | <b>17. INFORMANT</b> Address <b>Mrs. Mattie E. Rayne, (Daughter) Box 71, Fruitland, Maryland</b> |   |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201 coronary occlusion, probable</b><br>DUE TO (b) <b>coronary atherosclerosis, severe</b><br>DUE TO (c) <b>generalized arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                      |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b><br><br><b>years</b>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                      |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                      | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |  | <b>20f. (City or town) (County) (State)</b>   |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from Jan 1960, to MAR 1967, that (I) (we) last saw the deceased alive on March 4 1967, and that death occurred at 4:15 AM, from the causes and on the date stated above.</b>  |  |                                      |  |  |   |  |   |   |  |
| <b>22a. SIGNATURE</b> <i>Robert T. Akins</i>  |  |                                      |  |  |   | <b>22b. DATE SIGNED</b> <b>March 25 / 1967</b>   |   |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Robert T. Akins</b>  |  |                                      |  |  |   | <b>22d. ADDRESS</b> <b>Fruitland, Maryland</b>   |   |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>  |  |                                      | <b>23b. DATE THEREOF</b> <b>March 27, 1967</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Zion Cemetery</b>                |  | <b>23d. LOCATION (City, town or county) (State)</b> <b>Worcester County, Maryland</b> |   |  |
| <b>24. FUNERAL DIRECTOR</b> <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |  |                                      |  |  |   | <b>25a. REC'D BY REGISTRAR</b> <b>MAR 27 1967</b>  |   | <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04408

CERTIFICATE OF DEATH

04410

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Worcester</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>18 days</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pocomoke City</b>   |                                  | d. STREET ADDRESS<br><b>Market Street</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>IRA HERMAN RICHARD</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>MARCH 18 1967</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 27, 1883</b> |
| 9. AGE (In years last birthday) yrs.<br><b>83</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>11 11 11 11</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesclerk</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Clothing</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Worcester County, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Thomas Pilchard</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Hancock</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No --</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |
| 17. INFORMANT<br><b>Mrs Roy Mason</b>  |                                  | Address<br><b>Pocomoke City, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4201 Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><b>Coronary Arteriosclerosis</b><br>(c)<br><b>hypertension</b> |                                  | INTERVAL BETWEEN DEATH AND DEATH<br><b>11 days</b><br><b>unknown</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerosis</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)<br><b>Salisbury, Worcester, Md.</b>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/11/67</b> , 19 <b>67</b> to <b>3/18/67</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>3/11/67</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>Oswald Burton</b>   |                                  | 22b. DATE SIGNED<br><b>3/18/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Oswald Burton</b>   |                                  | 22d. ADDRESS<br><b>Medical Center, Salisbury, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>3-20-1967</b>  |  |
| 23c. NAME OF CEMETERY<br><b>First Baptist</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pocomoke City Wor. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Watson</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 21 1967</b>  |  |
| ADDRESS<br><b>Pocomoke City, Md.</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04409

CERTIFICATE OF DEATH

04411

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Wicomico</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓<br>o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>45 minutes</b>  |                                      |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Berlin</b>  |                                  | 23-2  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>  |                                  | d. STREET ADDRESS<br><b>Rt. #3, Box 276</b>   |                                      |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |                                      |
| 3. NAME OF DECEASED (Type or print)<br><b>Jesse M PURNELL</b>  |                                  | 4. DATE OF DEATH<br><b>March 7 1967</b>   |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-18-1896</b> |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Worcester</b>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Thomas Purnell</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Nancy Waters</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>21514-2905A</b>   |                                      |
| 17. INFORMANT<br><b>Katherine Purnell</b>  |                                  | Address<br><b>Berlin, Md.</b>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>5810</b><br>DUE TO (b) <b>Arteriosclerosis of heart</b><br>DUE TO (c) <b>last.</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Year</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1967</b> , to <b>March 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1967</b> , and that death occurred at <b>11:45 AM</b> , from causes on and on the date stated above. |                                  |   |                                      |
| 22a. SIGNATURE<br><b>A.C. Mitchell</b>   |                                  | 22b. DATE SIGNED<br><b>3-7-67</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. A. C. Mitchell</b>  |                                  | 22d. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Md.</b>   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>3-11-67</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Berlin, Md. Worcester</b>   |                                      |
| 24. FUNERAL DIRECTOR<br><b>Louise B. Jolley - Jersey Rd. Rt #2 Salis.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 16 1967</b>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |                                  |   |                                      |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04410

04412

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Wicomico</b> <span style="float: right;">b. STATE <b>Maryland</b></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>112 E. London Avenue</b> |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Wicomico</b></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b><br>d. STREET ADDRESS <b>112 E. London Avenue</b> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>LAURA (NMI) PUSEY</b>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>March</b> Day <b>14</b> Year <b>1967</b>  |  |  |  |
| <b>5. SEX</b><br><b>Female</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  |  |  |
| <b>8. DATE OF BIRTH</b><br><b>March 3, 1885</b>  |  | <b>9. AGE (In years last birthday)</b><br><b>82 yrs.</b>  |  | <b>IF UNDER 1 YEAR</b><br>Months <b>0</b> Days <b>11</b>  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Michigan</b>   |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |  |   |  | <b>13. FATHER'S NAME</b><br><b>George Crissey</b>   |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>Lucinda Cook</b>   |  |   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>  |  |  |  |
| <b>16. SOCIAL SECURITY NO.</b>   |  |   |  | <b>17. INFORMANT</b><br><b>Mary Z. Heiser, Snow Hill, Maryland</b>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Euphemism in Heart</b><br>DUE TO (b) <b>Myocarditis</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.                               |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>antherosclerosis</b>  |  |   |  |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1B.)   |  |   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <b>4:30</b> e.m. <b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Salisbury, Wicomico</b>  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from March 1967 to March 1967 that (I) (we) last saw the deceased alive on March 1967, and that death occurred at 4:30 PM from the causes and on the date stated above.</b>  |  |   |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><b>Carrie Hearn</b>   |  |   |  | <b>22b. DATE SIGNED</b><br><b>March 16/1967</b>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>Dr. Carrie Hearn</b>   |  |   |  | <b>22d. ADDRESS</b><br><b>226 N. Division St., Salisbury, Maryland</b>  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |  | <b>23b. DATE THEREOF</b><br><b>March 20, 1967</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Olivet Cemetery</b>   |  |  |  |
| <b>23d. LOCATION (City, town or county)</b><br><b>Worcester County, Maryland</b>   |  |   |  | <b>23e. ADDRESS</b>   |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |  |   |  | <b>25. REGISTERED BY REGISTRAR</b><br><b>MAR 21 1967</b>  |  |  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Charles Judge</b>  |  |   |  | <b>25c. DATE</b>  |  |  |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04411

CERTIFICATE OF DEATH

04413

|   |                                  |   |                                   |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> b. COUNTY<br><b>Wicomico</b>           |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | c. LENGTH OF STAY IN 1b   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>Main Street</b>   |                                   |
| 3. NAME OF DECEASED (Type or print)<br><b>CLYDE ELDERDICE REDDISH</b>   |                                  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>18</b> Year <b>1967</b>   |                                   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-8-06</b> |
| 9. AGE (In years lost birth day)<br><b>61</b> yrs.  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Wicomico Co. Custodian</b>                                 |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Wicomico County, Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                   |
| 13. FATHER'S NAME<br><b>George Edward Reddish</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Fannie Lee Phillips</b>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>212-14-4718</b>   |                                   |
| 17. INFORMANT<br><b>Mrs. Erna M. Reddish (Wife)</b><br><b>P.O. Box 99, Mardela, Maryland</b>  |                                  | Address   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) _____ (County) _____ (State) _____  |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-18</b> , 19 <b>67</b> , to <b>3-18</b> , 19 <b>67</b> , that (I) (we) lost the deceased on <b>3-18</b> , 19 <b>67</b> , and that death occurred at <b>10:20 PM</b> , from causes and on the date stated above.                             |                                  |   |                                   |
| 22a. SIGNATURE<br><b>Wilbur R. Ellis, Jr.</b>   |                                  | 22b. DATE SIGNED<br><b>3-18-67</b>  |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>WILBUR R. ELLIS, JR.</b>   |                                  | 22d. ADDRESS<br><b>MEDICAL CENTER, SALISBURY, MD.</b>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>March 21, 1967</b>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mardela Memorial Cemetery</b>  |                                  | 23d. LOCATION (City or Town) _____ (County) _____ (State) _____<br><b>Mardela, Maryland</b>   |                                   |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 21 1967</b>   |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                  |   |                                   |

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|--|--|--|-------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>   |  |  |                         | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  |  | c. LENGTH OF STAY IN 1b |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ORIOLE</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |  |  |                         | d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>Irene</b> First Middle Last   |  |  |                         | 4. DATE OF DEATH <b>March 29</b> 19 <b>67</b> Month Day Year   |  |   |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>  |                         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>DEC. 4, 1933</b>  |  |
| 9. AGE (In years last birthday) <b>33</b> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |                         | 11. BIRTHPLACE (County & State, or foreign country)<br><b>DAMES QUARTER, MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>HARRY BOZMAN</b>   |  |  |                         | 14. MOTHER'S MAIDEN NAME<br><b>GLADYS WEBSTER</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.<br><b>220-28-2020</b>  |                         | 17. INFORMANT Address<br><b>RICHARD REID ORIOLE, MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident, left</b><br><b>331X</b> DUE TO <b>Severe Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>None known</b><br>(c) <b>None known</b> |  |  |                         |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |  |  |                         |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                   |                         |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work   |                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/26/1967</b> to <b>3/29/1967</b> , that (I) (we) last saw the deceased alive on <b>3/28/1967</b> and that death occurred at <b>5:30 AM</b> , from causes and on the date stated above  |  |  |                         |  |  |   |  |
| 22a. SIGNATURE <b>[Signature]</b>  |  |  |                         | 22b. DATE SIGNED   |  | 22c. PHYSICIAN'S NAME (Type)  |  |
| 22d. ADDRESS   |  |  |                         | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>3/31/1967</b>  |                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OLIVER BEECHWOOD CEM.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>PRINCESS ANNE, MD.</b>                        |  |
| 24. FUNERAL DIRECTOR<br><b>LEVIN R. WILSON PRINCESS ANNE, MD.</b>  |  |  |                         | 25a. REC'D BY REGISTRAR<br><b>APR 6 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04413

CERTIFICATE OF DEATH

04415

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|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>   |  | d. STREET ADDRESS<br><b>Camden Avenue</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Russell</b> Middle <b>Truitt</b> Last <b>ROBERTS</b>  |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>5</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/20/1891</b>                                  |
| 9. AGE (In years lost birthday) yrs.<br><b>75</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Lab worker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>America</b>  |  |
| 13. FATHER'S NAME<br><b>Thomas S. Roberts</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret P. Collier</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>—</b>   |  | 16. SOCIAL SECURITY NO.<br><b>577-16-8790</b>   |  |
| 17. INFORMANT<br><b>Thomas S. Roberts</b>   |  | Address<br><b>Baltimore, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4200 Congestive heart failure</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>Pulmonary tuberculosis</b>                                      |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>6-8 weeks</b><br>Years   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Pleural effusion (left), probably tuberculosis</b>   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August 26</b> , 19 <b>65</b> , to <b>March 5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 5</b> , 19 <b>67</b> , and that death occurred at <b>1:00 P</b> M, from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><b>C. H. Winnacott</b>  |  | 22b. DATE SIGNED<br><b>3-6-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. C. H. Winnacott</b>   |  | 22d. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>3/8/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Jonestown, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>C. J. Bivette</b>  |  | 25. REC'D BY REGISTRAR<br><b>Charles Judge</b>  |  |
| 25a. DATE<br><b>MAR 10 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| 04414   |                                  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |   | 04416  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital D.O.A.</b>  |                                  |   | d. STREET ADDRESS<br><b>306 Pineway</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDGAR</b> Middle <b>LEE</b> Last <b>RUSH</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>1</b> Year <b>19 67</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>July 20, 1910</b>  |  | 9. AGE (In years lost birthday)<br><b>56 yrs.</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Factory Manager</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |   |
| 13. FATHER'S NAME<br><b>Charlie Rush</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>(Unk.)</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>225-03-2720</b>   |   | 17. INFORMANT<br><b>Mrs. Virginia L. Rush (Wife)</b><br><b>306 Pineway, Salisbury, Maryland</b>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured aortic aneurysm - abdominal</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____   |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                               |   |
|   |                                  | 20f. (City or town)   |   | (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |  |   |
| ACTUAL SIGNATURE<br><i>Earl L. Royer</i>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22. DATE SIGNED<br><b>March 2 /1967</b>  |   |
| EXAMINER'S NAME (Type)<br><b>Dr. Earl L. Royer</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
|   |                                  | Address (Street, city, town, or county)<br><b>409 Camden Ave., Salisbury, Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>March 4, 1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Springhill Memory Gardens</b>                               |   |
|   |                                  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>                          |   |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 3 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |   |

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*[Handwritten signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04415

CERTIFICATE OF DEATH

04417

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|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>  |  | c. LENGTH OF STAY IN lb <b>since 11/7/66</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pine Bluff State Hospital</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>ORVAL GUY SANDERS</b>   |  | 4. DATE OF DEATH <b>March 4 1967</b>   |   |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>8/9/1918</b>                                      |
| 9. AGE (In years last birthday) <b>48</b>  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Somerset Co., Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>Granville Sanders</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Amanda Macon</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W. War II</b>   |  | 16. SOCIAL SECURITY NO. <b>219-07-4360</b>   |   |
| 17. INFORMANT <b>Records of Pine Bluff Hospital</b>  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b><br>DUE TO (b) <b>10021</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>-----</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/7</b> , 19 <b>66</b> , to <b>3/4</b> , 1967, that (I) (we) last saw the deceased alive on <b>3/4/19 67</b> , and that death occurred on <b>4:15am</b> , from causes on and on the date stated above.                                 |  |  |   |
| 22a. SIGNATURE <b>E.P. Ritchings</b>   |  | 22b. DATE SIGNED <b>March 4, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>E.P. Ritchings, M.D.</b>   |  | 22d. ADDRESS <b>Pine Bluff State Hospital</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE THEREOF <b>3/6/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>QUINTON CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State) <b>COSTON, MARYLAND</b> |
| 24. FUNERAL DIRECTOR <b>LEVIN R. WILSON</b>  |  | 25a. REC'D BY REGISTRAR <b>DATE MAR 8 1967</b>   |   |
| ADDRESS <b>PRINCESS ANNE, MD.</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04417

CERTIFICATE OF DEATH

04419

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b><br>MARYLAND  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |                                  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Greenwood</b> 46-3 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |                                  |   | d. STREET ADDRESS   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Laura May Sharp</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>March 22 1967</b>  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 15, 1902</b>  | 9. AGE (In years last birthday) Yrs.<br><b>64</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>22 19 67</b>                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>                                      |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |   | 13. FATHER'S NAME<br><b>John Buckalew</b>   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Maude Elizabeth Howard</b>  |                                  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>                      |   |   |
| 16. SOCIAL SECURITY NO.<br><b>221-05-3209</b>  |                                  |   | 17. INFORMANT<br>Address<br><b>Mr. Jesse Sharp Greenwood, Del.</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary sclerosis Heart Disease</b><br>4200 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) |                                  |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town)  |                                  | (County)  |   | (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-22</b> , 19 <b>67</b> , to <b>3-22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-22</b> , 19 <b>67</b> , and that death occurred at <b>10 P</b> M, from causes and on the date stated above.               |                                  |   |   |   |   |
| 22a. SIGNATURE<br><b>W. R. Ellis</b>   |                                  |   | 22b. DATE SIGNED<br><b>3-27-67</b>  |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>W. R. Ellis</b>   |                                  |   | 22d. ADDRESS<br><b>Medical Bldg. Salisbury, Md.</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>3/26/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johnstown</b>  |   |
| 23d. LOCATION (City or Town)<br><b>Greenwood</b>   |                                  | (County)<br><b>Sussex</b>   |   | (State)<br><b>Del.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Lewis D. McKnatt</b>  |                                  |   | ADDRESS<br><b>HARRINGTON, Del.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 29 1967</b>   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |   |   |   |

01117

STATE OF CALIFORNIA

01117

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04418

CERTIFICATE OF DEATH

04420

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Snow Hill</b>  |   |
| c. LENGTH OF STAY IN 1b<br><b>410 days</b>  |  | d. STREET ADDRESS<br><b>240 Martin Street</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Grace Lucille Smith</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>March 26 19 67</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>Dec. 22, 1898</b>  |
| 9. AGE (In years last birthday)<br><b>68 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own H me</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John Sheraton</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Elton L. Smith, Snow Hill, Md.</b>  |  | Address<br><b>240 Martin St.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b><br>DUE TO (b) <b>Bronchopneumonia - aspiration</b><br>DUE TO (c) <b>last.</b>  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>few hrs</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9</b> , 19 <b>66</b> , to <b>Mar. 26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 26</b> , 19 <b>67</b> , and that death occurred at <b>1:25 P.M.</b> from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>A. C. Mitchell</b>   |  | 22b. DATE SIGNED<br><b>3/27/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. C. Mitchell, M.D.</b>   |  | 22d. ADDRESS<br><b>Deer's Head Hospital; Salisbury, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>3-28-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Union-Greenbackville</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Worcester, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Gerald C. Bonds</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 29 1967</b>   |   |
| ADDRESS<br><b>Snow Hill Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

05110

05110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04419

CERTIFICATE OF DEATH

04421

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Baltimore City</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |   | c. LENGTH OF STAY IN 1b<br><b>5452 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>  |   | d. STREET ADDRESS<br><b>UNK.</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Walter</b>  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>5</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-29-1893</b>                                 |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.  |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>UNK.</b>  |   | 12. KIND OF BUSINESS OR INDUSTRY<br><b>UNK.</b>  |   |
| 13. BIRTHPLACE (County & State, or foreign country)<br><b>Wakefield, Virginia</b>  |   | 14. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 15. FATHER'S NAME<br><b>UNK.</b>   |   | 16. MOTHER'S MAIDEN NAME<br><b>UNK.</b>  |   |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes</b>  |   | 18. SOCIAL SECURITY NO.<br><b>UNK.</b>   |   |
| 19. INFORMANT<br><b>Hospital Records</b>   |   | Address<br><b>VAH</b>  |   |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br>DUE TO (b) <b>Bronchopneumonia</b><br>DUE TO (c) <b>7 days</b>  |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic bronchitis</b>   |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 31</b> , 19 <b>67</b> , to <b>March 5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 5</b> , 19 <b>67</b> , and that death occurred at <b>2:55 AM</b> , from causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE<br><b>C. H. Winnacott</b>   |   | 22b. DATE SIGNED<br><b>3-6-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. C. H. Winnacott</b>  |   | 22d. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Md.</b>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>3-10-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat'l Cem</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Morton + Dyett Funeral Home</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   | DATE <b>MAR 9 1967</b>   |   |

04431

CERTIFICATE OF DEATH

04430

LOCAL RECORDS

LOCAL RECORDS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04420

CERTIFICATE OF DEATH

04422

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pocomoke City</b> 23-2  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>325 Winter Quarters Drive</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>BEATRICE CANNON STEVENSON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>7</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 27, 1893</b> |
| 9. AGE (In years last birthday) <b>73</b> yrs.  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Banking</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Worcester County, Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>James Edison Stevenson</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Hearne</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-12-1841</b>  |  |
| 17. INFORMANT<br><b>Miss Hilda Stevenson, Pocomoke City, Md.</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO <b>Coronary Artery Thrombosis</b><br>(b) <b>2 days</b><br>(c) <b>2 days</b>     |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Congestive Heart Failure - Pulmonary Emboli</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/5/1967</b> , to <b>3/7/1967</b> that (I) (we) last saw the deceased alive on <b>3/7/1967</b> and that death occurred at <b>11 A.M.</b> from causes and on the date stated above. |                                  | 22b. DATE SIGNED   |  |
| 22a. SIGNATURE<br><b>O. J. BURTON, M.D.</b>   |                                  | 22c. PHYSICIAN'S NAME (Type)   |  |
| 22d. ADDRESS<br><b>Medical Center, Salisbury, Md.</b>   |                                  | 22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>3-10-1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Presbyterian</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pocomoke City Wor. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Watson</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 13 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  | 25c. ADDRESS<br><b>Pocomoke City, Md.</b>  |  |

63230

55120

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04421

CERTIFICATE OF DEATH

04423

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. LENGTH OF STAY in 1b<br><b>Adm. in 1b 3/4/67</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |  |   | d. STREET ADDRESS<br><b>315 Penn Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Connie</b> Middle <b>ELLEN</b> Last <b>Stevenson</b>   |  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>7</b> Year <b>1967</b>  |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> <b>Baby</b> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>February 13, 1967</b>  | 9. AGE (In years lost birthday) yrs.<br><b>0</b>   | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>24</b> Hours <b></b> Min. <b></b>           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>----</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Salisbury, Maryland</b>                    |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 13. FATHER'S NAME<br><b>Robert Lee Stevenson</b>  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Patricia Ellen Powell</b>   |  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>                        |  |  |
| 16. SOCIAL SECURITY NO.<br><b>---</b>  |  |   | 17. INFORMANT Address<br><b>Mr. Robert Lee Stevenson 315 Penn Street, Salisbury, Maryland</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7630</b> IMMEDIATE CAUSE (a) <b>Diffuse Pneumonia - Right Lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>aprox 4 days</b><br>(c) <b></b> |  |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Patent Ductus Arteriosus</b>   |  |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b><br>p.m. <b></b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>3/4</b> , 19 <b>67</b> , to <b>3/7</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>3/7</b> , 19 <b>67</b> , and that death occurred at <b>10:50</b> A.M., from causes and on the date stated above.                                    |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Alfred C Kolls</b>  |  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        |  | 22b. DATE SIGNED<br><b>3/8/67</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Alfred C. Kolls</b>   |  |   | 22d. ADDRESS<br><b>Medical Center Salisbury Maryland</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>March 10, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Riverside Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Worcester Co., Maryland</b>   |  |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>   |  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 9 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                  |

7-230120

03233

EXHIBIT OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05968

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Wicomico</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u><br>c. LENGTH OF STAY IN 1b <u>25 yrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u><br>d. STREET ADDRESS <u>137 Delaware Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>JOSHA E. SWEAT</u> Middle Last<br><b>4. DATE OF DEATH</b> <u>3 23 1967</u> Month Day Year   |  |  |  | <b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>NEGRO</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JULY 31, 1908</u> <b>9. AGE</b> (In years last birthday) <u>58</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>TIMBERMAN</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>NORFOLK, VA.</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u> |  |  |  | <b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> <b>16. SOCIAL SECURITY NO.</b> <u>718-10-8088 <b>17. INFORMANT</b> <u>Lillian Sweet</u> Address <u>137 Delaware Ave.</u> </u>   |  |  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Disease</u><br>4200 DUE TO (b) <u>Coronary Artery Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Generalized Atherosclerosis</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u><br><u>Indefinite</u> |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____  |  |  |  | <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> (County) (State)   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9 AM 1967</u> <b>to</b> <u>23 Mar 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>23 Mar 1967</u> <b>and that death occurred at</b> <u>11:30 PM</u> <b>from the causes and on the date stated above.</b>        |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b> <u>E. Parnell</u> <b>22b. DATE SIGNED</b> <u>24 Mar 67</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>E.A. Parnell M.D.</u> <b>22d. ADDRESS</b> <u>652 W. Main St. Salisbury, Md.</u>  |  |  |  | <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3-27-67</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Acres Cem</u> <b>23d. LOCATION (City, town or county)</b> <u>Salisbury Md</u> (State)  |  |  |  |
| <b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>West Funeral Home</u> <b>ADDRESS</b> <u>Salisbury Md</u>  |  |  |  | <b>25a. REC'D BY REGISTRAR</b> <u>APR 12 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04423

CERTIFICATE OF DEATH

04424

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Snow Hill 23-2</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>  |  |   | d. STREET ADDRESS<br><b>RFD #2</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Baby Girl (Nina) TAYLOR</b>   |  |   | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>11</b> Year <b>1967</b>  |   |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 9 1947</b>  |   | 9. AGE (In years lost birthday) yrs. <b>19</b> Months <b>4</b> Days <b>2</b> Hours <b>44</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Snow Hill Maryland</b>                                |   |
| 13. FATHER'S NAME<br><b>Clarence Robins</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Cerinda Taylor</b>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Clarence Robins, Snow Hill, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atelectasis</b><br>DUE TO <b>Prematurity (wt 1245 gms)</b><br>DUE TO <b>about 44 hrs</b><br>DUE TO <b>last.</b>  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>about 44 hrs</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> , 19 <b>67</b> , to <b>3/11</b> , 19 <b>67</b> , that (II) (we) last saw the deceased alive on <b>3/10</b> , 19 <b>67</b> , and that death occurred at <b>9:52</b> M, from causes and on the date stated above. |  |   |  |   |   |
| 22a. SIGNATURE<br><b>Alfred C. Holls</b> M.D.  |  |   | 22b. DATE SIGNED<br><b>3/11/67</b>   |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Alfred C. Holls</b>  |
| 22d. ADDRESS<br><b>Medical Center Salisbury Maryland</b>   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Mar. 13, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Friendship</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Snow Hill Maryland</b>   |   |   |
| 24. FUNERAL DIRECTOR<br><b>James F. Allen, Snow Hill, Md.</b>  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 13 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

ES&amp;A

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1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04424

CERTIFICATE OF DEATH

04425

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Worcester</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Stockton</b>   |                                  | d. STREET ADDRESS<br><b>---</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Bessie Elizabeth Timmons</b>  |                                  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>21</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 1, 1888</b> |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.   |                                  | 10. BIRTHPLACE (County & State, or foreign country)<br><b>Worcester County, Maryland</b>  |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Joshua Davis</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sallie Merritt</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>213-22-4735</b>   |  |
| 17. INFORMANT<br><b>Mrs William Wittman, Binghamton, N.Y.</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4200 CARDIAC ARREST</b><br>DUE TO (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b><br>DUE TO (c) <b>CARDIAC FAILURE</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yr</b><br><b>1 yr</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ARTHRITIS</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>FEB 1</b> , 19 <b>67</b> , to <b>MAR 21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>MAR 20</b> , 19 <b>67</b> , and that death occurred at <b>2:57</b> P.M. from causes and on the date stated above. |                                  |   |  |
| 22a. SIGNATURE<br><b>Robert C. LaMar</b>  |                                  | 22b. DATE SIGNED<br><b>3/21/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert C. LaMar, M.D.</b>  |                                  | 22d. ADDRESS<br><b>104 Bay St., Snow Hill, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>3-24-1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Porterville Methodist</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Stockton, Wor. Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Watson</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 27 1967</b>  |  |
| ADDRESS<br><b>Pocomoke City, Md.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

CS 10

45242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04425

CERTIFICATE OF DEATH

04426

|   |  |   |                                      |
|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>                |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. LENGTH OF STAY IN 1b   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |  | d. STREET ADDRESS<br><b>9 POWELLTON AVE</b>   |                                      |
| 3. NAME OF DECEASED<br>(Type or print) <b>LULA</b> First Middle Lost  |  | 4. DATE OF DEATH<br><b>March 22 1967</b> Month Day Year   |                                      |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-21-1918</b> |
| 9. AGE (In years lost birthday) <b>49</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HAIRDRESSER</b>  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>VA.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                      |
| 13. FATHER'S NAME<br><b>ELIHU G. JOHNSON</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>LAURA TAYLOR</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |                                      |
| 17. INFORMANT<br><b>BRENDA WILLIAMS</b>   |  | Address<br><b>BERLIN MD.</b>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>171X</b><br>IMMEDIATE CAUSE (a) <b>Carcinoma of cervix - widespread metastasis</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) |  | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |                                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>12:30</b> P.M. from causes and on the date stated above.   |  |   |                                      |
| 22a. SIGNATURE<br><b>Norm W. Jones</b>  |  | 22b. DATE SIGNED<br><b>3-23-67</b>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)  |  | 22d. ADDRESS  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>3-25-67</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET MEM. PK.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BERLIN. WOR. MD.</b>  |                                      |
| 24. FUNERAL DIRECTOR<br><b>ULLRICH FUNERAL HOME</b>   |  | 25. REG'D BY REGISTRAR<br><b>Charles Judge</b>  |                                      |
| ADDRESS<br><b>BERLIN, MD.</b>   |  | DATE<br><b>MAR 27 1967</b>  |                                      |

04552

STATE OF TEXAS

04552

|                        |  |                      |  |                      |  |                       |  |                     |  |                     |  |
|------------------------|--|----------------------|--|----------------------|--|-----------------------|--|---------------------|--|---------------------|--|
| Name of Deceased       |  | Age                  |  | Sex                  |  | Race                  |  | Date of Death       |  | Place of Death      |  |
|                        |  |                      |  |                      |  |                       |  |                     |  |                     |  |
| Cause of Death         |  | Manner of Death      |  | Occupation           |  | Education             |  | Marital Status      |  | Social Status       |  |
|                        |  |                      |  |                      |  |                       |  |                     |  |                     |  |
| Signature of Physician |  | Signature of Coroner |  | Signature of Witness |  | Signature of Deceased |  | Signature of Family |  | Signature of Other  |  |
|                        |  |                      |  |                      |  |                       |  |                     |  |                     |  |
| Date of Report         |  | Time of Report       |  | Place of Report      |  | Name of Reporter      |  | Title of Reporter   |  | Address of Reporter |  |
|                        |  |                      |  |                      |  |                       |  |                     |  |                     |  |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE  
PUBLIC HEALTH SERVICE OF THE UNITED STATES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF VITAL RECORDS  
WASHINGTON, D. C. 20495



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G387 3/30/67 pc

04426

CERTIFICATE OF DEATH

04427

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Delaware</b> b. COUNTY<br><b>Sussex</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Selbyville</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |  | d. STREET ADDRESS<br><b>16-3</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Helen Townsend</b>   |  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>23</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/16/1919</b>  |
| 9. AGE (In years last birthday)<br><b>47 1/2</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>14</b> Hours <b>48</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Worcester, Maryland U.S.A.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Clarence Harman</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Althea Collick</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>214-12-5626</b>   |   |
| 17. INFORMANT<br><b>Norman Townsend</b>   |  | Address<br><b>Selbyville, Dela.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>171X Congestive heart failure</b><br>DUE TO (b) <b>Ca Cx stage IV</b><br>DUE TO (c) <b>1465</b>                               |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1465</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/15, 1967</b> to <b>3/22, 1967</b> , that (I) (we) last saw the deceased alive on <b>3/22, 1967</b> , and that death occurred at <b>1:30 PM</b> , from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>Stedman W. Smith</b>   |  | 22b. DATE SIGNED<br><b>3/23/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stedman W. Smith</b>   |  | 22d. ADDRESS<br><b>Salisbury, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>3/27/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Coolspring Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Girdletree, Worces. Md.</b>                   |
| 24. FUNERAL DIRECTOR<br><b>Richard T. Watson</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 27 1967</b>   |   |
| ADDRESS<br><b>Selbyville, Dela.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |   |   |  |  |   |   |  |  |  |
|---|--|-------------------------------|---|---|--|--|---|---|--|--|--|
| 04427   |  |                               |   |   | 04428  |  |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b><br>c. LENGTH OF STAY IN 1b <b>14 Months</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>XX</b> |  |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution - Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b><br>d. STREET ADDRESS <b>Zion Church Road</b><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Edward</b>  |  |                               | First <b>Edward</b> Middle <b>Truitt</b> Last <b>Truitt</b> |   | 4. DATE OF DEATH <b>March 2, 1967</b>  |  | Month <b>March</b> Day <b>2</b> Year <b>19</b>                    |   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>May 7, 1889</b>  |   | 9. AGE (in years last birthday) <b>77</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Poultryman</b>  |  |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>         |  |  |  |
| 13. FATHER'S NAME <b>Sampson Edward Truitt</b>  |  |                               |   |   | 14. MOTHER'S MAIDEN NAME <b>Alice Powell</b>   |  |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>XX</b>   |  |                               | 16. SOCIAL SECURITY NO. <b>217-36-1164</b>                  |   | 17. INFORMANT <b>Esther H. Truitt</b>  |  | Address <b>Salisbury, Md.</b>                                     |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1810 Carcinoma of urinary bladder</b><br>DUE TO (b) <b>with metastases to lungs</b><br>DUE TO (c) <b>1 year</b>                                       |  |                               |   |   |  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                               |   |   |  |  |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                               |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)            |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6/14, 1936</b> , to <b>death</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Mar 2</b> 19 <b>67</b> , and that death occurred at <b>4:57 PM</b> , from the causes and on the date stated above. |  |                               |   |   |  |  |   |   |  |  |  |
| 22a. SIGNATURE <b>Ernest Larmore</b>  |  |                               |   |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED <b>3/4/67</b>                  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>ERNEST LARMORE</b>  |  |                               |   |   |  | 22d. ADDRESS <b>Delmar, Del.</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |                               | 23b. DATE THEREOF <b>3/5/67</b>                             |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Lewis</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Willards, Md.</b> |   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Kater Whaley Salisbury, Del.</b>  |  |                               |   |   |  | 25a. REC'D BY REGISTRAR <b>MAR 7 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |  |  |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04428

## CERTIFICATE OF DEATH

04429

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Wicomico</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u><br>c. LENGTH OF STAY IN lb<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23.2<br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>LELIA</u><br>First Middle Last<br><b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>Negro</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept 9 1888</u><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs.<br>IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min. |  |   | <b>4. DATE OF DEATH</b> <u>MARCH 20</u> 19 <u>67</u><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Snow Hill Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |  |   |  |
| <b>13. FATHER'S NAME</b> <u>Frank Tull</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u><br><b>16. SOCIAL SECURITY NO.</b> <u>None</u>   |  |   | <b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah (unknown)</u><br><b>17. INFORMANT</b> <u>Motherine Armstrong</u> Address <u>4033 Spring Garden ST. Phila. Pa.</u>   |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4221</u> IMMEDIATE CAUSE (a) <u>Delirium Tremens</u><br>DUE TO (b) <u>A.S.C.V.D.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><u>Diabetes - mild - untreated</u>   |  |   |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)                 |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. 19<br>p.m.  |  | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town) (County) (State)</b>   |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-20-67</u> , 19 <u>67</u> , <b>to</b> <u>3-20-67</u> , 19 <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3-20-67</u> 19 <u>67</u> , <b>and that death occurred at</b> <u>9:35</u> M, <b>from causes and on the date stated above.</b>   |  |   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Joseph F. Fitzgerald, M.D.</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22c. PHYSICIAN'S NAME (Type)</b>  |  |   |  | <b>22b. DATE SIGNED</b><br><u>3/20/67</u>  |  |   |  |
| <b>22d. ADDRESS</b><br><u>Medical Center</u>   |  |   |  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>Mar. 25, 1967</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Ebenezer</u>   |  |   |  |
| <b>23d. LOCATION (City or Town) (County) (State)</b><br><u>Snow Hill Maryland</u>  |  |   |  |  |  |   |  |
| <b>24. FUNERAL DIRECTOR</b><br><u>Thomas F. Thomas, Snow Hill, Md.</u> ADDRESS   |  |   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>MAR 29 1967</u>   |  |   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>  |  |   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05210

STATE OF NEW YORK

05210

IN SENATE

JANUARY 1, 1911

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1910

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

1911

PRINTED BY THE UNIVERSITY OF THE STATE OF NEW YORK

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04429

04430

|  |  |                                      |  |   |  |   |  |   |  |  |  |   |  |
|--|--|--------------------------------------|--|---|--|---|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Wicomico</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>                           |  |                                      |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> ✓<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u><br>d. STREET ADDRESS <u>6650 Collingdale Rd</u> 13-2<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>RUTH</u> First <u>Ulrich</u> Middle <u>Ulrich</u> Last   |  |                                      |  | <b>4. DATE OF DEATH</b> <u>March 25</u> 19 <u>67</u><br>Month Day Year  |  |   |  |   |  |  |  |   |  |
| <b>5. SEX</b> <u>Female</u>  |  | <b>6. COLOR OR RACE</b> <u>White</u> |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <u>Sept. 23</u> 19 <u>01</u>  |  | <b>9. AGE</b> (In years last birthday) <u>65</u> yrs.                 |  | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min. |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>  |  |                                      |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OVERSEER</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BALTIMORE MD.</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b>                                   |  |  |  |   |  |
| <b>13. FATHER'S NAME</b> <u>PETER KLINGELHOFFER</u>  |  |                                      |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Amalia WOLF</u>  |  |   |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)   |  |                                      |  | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT</b> Address  |  |   |  |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>(b) <u>Hypertensive Cardio Vascular Disease</u><br>(c) <u>443X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                      |  |   |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hrs</u><br><u>Unknown</u>                            |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |                                      |  |   |  |   |  |   |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                      |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1B.)   |  |   |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. 19   |  |                                      |  | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)                           |  |  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/25/67</u> <u>1967</u> , <b>to</b> <u>3/25/67</u> <u>1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3/25/67</u> <u>1967</u> , <b>and that death occurred at</b> <u>7:45</u> <u>P.</u> <b>from causes and on the date stated above.</b>     |  |                                      |  |   |  |   |  |   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>[Signature]</u>  |  |                                      |  |   |  | <b>22b. DATE SIGNED</b>   |  | <b>22c. PHYSICIAN'S NAME</b> (Type)                                   |  |  |  |   |  |
| <b>22d. ADDRESS</b>  |  |                                      |  |   |  | <b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | <b>22f. DATE SIGNED</b>   |  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  |                                      |  | <b>23b. DATE THEREOF</b> <u>3/29/67</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn Cem.</u>  |  | <b>23d. LOCATION</b> (City or Town) (County) (State) <u>Balto. MD</u> |  | <b>23e. REC'D BY REGISTRAR</b> <u>Charles Judge</u>  |  |   |  |
| <b>24. FUNERAL DIRECTOR</b> <u>Charles A. Heumann</u>  |  |                                      |  |   |  | <b>25. REGISTRAR'S SIGNATURE</b>  |  | <b>25a. DATE</b> <u>MAR 31 1967</u>                                   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04430

CONFIDENTIAL

04430

CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |  |  |  |   |   |  |
|--|--|-------------------------------|--|--|--|--|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                               |  |  |  |  |   |   |  |
| 04430  |  |                               |  |  | CERTIFICATE OF DEATH   |  |   | 04431   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wicomico</u> MARYLAND  |  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Salisbury</u>   |  |                               | c. LENGTH OF STAY IN 1b                              |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>OCEAN CITY</u> 23-2                                   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Peninsula General Hospital</u>  |  |                               |  |  | d. STREET ADDRESS  |  |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Annie B. Wainwright</u>  |  |                               |  |  | 4. DATE OF DEATH <u>March 21 1967</u>  |  |   |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>OCT. 28 1907</u> 84 yrs.                           |   | 9. AGE (In years last birthday) <u>84</u> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>BERLIN MD</u>  |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>GEORGE TAYLOR</u>  |  |                               |  |  | 14. MOTHER'S MAIDEN NAME<br><u>ALICE FAY MCCABE</u>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |                               | 16. SOCIAL SECURITY NO.                              |  | 17. INFORMANT <u>Mrs. Hilda Ruth Ocean City Md</u> Address   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Arterial Hemorrhage</u><br>331X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>DUE TO</u><br>(c) <u>DUE TO</u> |  |                               |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>22 hrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |                               |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                               |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 20, 1967</u> to <u>Mar. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar. 21, 1967</u> , and that death occurred at <u>7:50</u> M, from causes on and on the date stated above.  |  |                               |  |  |  |  |   |   |  |
| 22a. SIGNATURE <u>Alan J. Salzman</u>  |  |                               |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    |  |   | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)   |  |                               |  |  | 22d. ADDRESS   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  |                               | 23b. DATE THEREOF<br><u>3/23/67</u>                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>EVERGREEN</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>BERLIN WOR MD</u> |   |  |
| 24. FUNERAL DIRECTOR<br><u>Anna R. Burkage Berlin Md</u>   |  |                               |  |  | 25a. REC'D BY REGISTRAR<br><u>MAR 27 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>                 |   |  |

04431

STATEMENT OF DEATH

04430

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| Name of Deceased       |  | Date of Death          |  |
| Sex                    |  | Age                    |  |
| Place of Birth         |  | Date of Birth          |  |
| Cause of Death         |  | Place of Death         |  |
| Time of Death          |  | Signature of Physician |  |
| Signature of Informant |  | Signature of Registrar |  |
| Date of Statement      |  | Date of Registration   |  |

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VR A15 (4)  
 20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |   |   |  |   |  |   |  |  |  |
| 04431   |  |   |   |   |  | 04432   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>  |  |   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Nanticoke</u>  |  |   |   | c. LENGTH OF STAY IN 1b<br><u>30 yrs</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Nanticoke</u>  |  |   |  | d. STREET ADDRESS<br><u>221</u>                    |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |   |   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  |   | First <u>Samuel</u> Middle <u>Waxfield</u> Last <u>Waxfield</u> |   |  | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>15</u> Year <u>1967</u>   |  |   |  |  |  |
| 5. SEX<br><u>M</u>  |  | 6. COLOR OR RACE<br><u>Negro</u>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>12/6/1893</u>  |  | 9. AGE (In years last birthday)<br><u>73</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>3</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Self</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Dorchester, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |   |  |  |  |
| 13. FATHER'S NAME<br><u>Samuel Waxfield</u>   |  |   |   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>—</u>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>Yes</u> <u>World War I</u>   |  |   |   | 16. SOCIAL SECURITY NO.<br><u>215-18-4956</u>   |  | 17. INFORMANT<br><u>Stella Holbrook, Nanticoke, Md.</u>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u><br><u>1810</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. (c)<br>DUE TO |  |   |   |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u>    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from..... 19....., to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 230 A.M., from the causes and on the date stated above.   |  |   |   |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><u>N. W. Todd</u>   |  |   |   |   |  | M.D.  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED                                   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>N. W. Todd</u>   |  |   |   |   |  | 22d. ADDRESS<br><u>Med. Center Salisbury, Md.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>3/19/67</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Nanticoke Cem.</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Nanticoke, Md.</u>   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE<br><u>C. J. W. Smith, Bivzive, Md.</u>  |  |   |   |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><u>MAR 27 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |

06335

18410

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "M. W." and "B. W." are faintly visible.]*



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04432

CERTIFICATE OF DEATH

04433

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Wicomico</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>22-1</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>613 Church Street</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Harry EBEN Welch</b>  |                                  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>3</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>June 29, 1904</b> |
| 9. AGE (In years lost birthday) <b>62</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>4</b> Hours <b></b> Min. <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Driver</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Harry Vincent Welch</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Ellison</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b></b>   |  |
| 17. INFORMANT<br><b>Mrs. Rebecca Bradford (Daughter)</b><br><b>R.D.#3, Box 157M, Bradenton, Florida 33505</b>   |                                  | Address<br><b></b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe bilateral pneumonia</b><br>DUE TO <b>Chronic bronchitis</b><br>DUE TO <b>Chronic lymphatic leukemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>2040</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>Days</b><br><b>years.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Rheumatic Heart disease with congestive failure</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b></b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b></b>   |                                  | 20f. (City or town) (County) (State)<br><b></b>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept 22, 1966</b> , to <b>March 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 3, 1967</b> , and that death occurred at <b>12:40 AM</b> , from causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>Thomas P. Bigbee</b>   |                                  | 22b. DATE SIGNED<br><b>March 3, 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Thomas P. Bigbee</b>   |                                  | 22d. ADDRESS<br><b>Maryland Ave., Salisbury, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>March 7, 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Salisbury, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 9 1967</b>   |  |
|   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

LEAD

2628

1. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04433

**CERTIFICATE OF DEATH**

04434

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Wicomico</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | c. LENGTH OF STAY IN 1b  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |                                  | d. STREET ADDRESS<br><b>R.D.#3, AirPort Road</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Peninsula General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) (Baby)<br>First Middle Last<br><b>White</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>MARCH 19 1967</b>   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 18, 1967</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>0</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>0 0 17 58</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Salisbury, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Ronald Lee White</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sandra Sue Vickers</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Mr. Ronald Lee White (Father)</b>   |                                  | Address<br><b>R.D.#3, AirPort Road, Salisbury, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atelectasis</b><br>7620 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>N/A</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/18, 1967</b> , to <b>3/19, 1967</b> , that (I) (we) last saw the deceased alive on <b>3/19 1967</b> , and that death occurred at <b>10:00</b> M, from causes and on the date stated above.                     |                                  |  |   |
| 22a. SIGNATURE<br><b>Dr. William B. Smith</b> M.D.  |                                  | 22b. DATE SIGNED<br><b>3/19/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>  |                                  | 22d. ADDRESS<br><b>Salisbury, Maryland</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>March 22, 1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Whaylesville Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Worcester Co., Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 21 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                  |  |   |

65230

4520

528 15-2324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04434

CERTIFICATE OF DEATH

04435

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>  |  | c. LENGTH OF STAY IN lb<br><b>71 days</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chance</b> 19-2 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>   |  | d. STREET ADDRESS<br><b>--</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>OLIVE</b> Middle <b>SARAH</b> Last <b>WHITELOCK</b>   |  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>15</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3 24 1872</b>   |
| 9. AGE (In years last birthday)<br><b>94</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>household</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                                 |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Joseph Arminger</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Willing</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  | 17. INFORMANT<br><b>Charles Whitelock, Chance, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>493X<br>DUE TO<br>(b) <b>Senility</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>--</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>--</b>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 3, 1967</b> , to <b>Mar. 15, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 15, 19 67</b> , and that death occurred at <b>2:20 PM</b> , from causes and on the date stated above.                                 |  |   |  |
| 22a. SIGNATURE<br><b>Andrew C. Mitchell</b>   |  | 22b. DATE SIGNED<br><b>3/15/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Andrew C. Mitchell</b>   |  | 22d. ADDRESS<br><b>Deer's Head State Hospital, Salisbury, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 23b. DATE THEREOF<br><b>3/17/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Chance, Somerset, Md.</b>                          |
| 24. FUNERAL DIRECTOR<br><b>Leroy B. Webster</b>   |  | 25. REC'D BY REGISTRAR<br><b>Princess Anne, Md. MAR 20 1967</b>   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

04334

CONFIDENTIAL - DECLASSIFIED

04334

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100. [Illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

04433

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04436

|  |                                  |   |   |   |  |  |   |
|--|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b>   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> |  |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>4 mths</b>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Wicomico Nursing Home</b>   |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WALTER</b> Middle <b>WISSERT</b> Last <b>WISSERT</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>8</b> , Year <b>19 67</b>   |  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 6, 1880</b> | 9. AGE (In years last birthday)<br><b>86</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>86</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>                           |   |
| 1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>  |                                  | 1Db. KIND OF BUSINESS OR INDUSTRY<br><b>Unk</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Brooklyn, New York</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                 |   |
| 13. FATHER'S NAME<br><b>Rudolph Wissert</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Widner</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>135-03-5346</b>   |   | 17. INFORMANT<br><b>Mr. Thomas O. Tyler, Vienna, Maryland</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>Cerebral Arteriosclerosis</b><br>DUE TO <b>Arteriosclerotic Cardiovascular Dis.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of prostate</b> |                                  |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>Yes</b><br><b>Yes</b> |
| 20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>now</b> , 19 <b>66</b> to <b>March 8, 19 66</b> , that (I) (we) last saw the deceased alive on <b>Feb 6, 19 67</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.   |                                  |   |   |   |  |  |   |
| 22a. SIGNATURE<br><b>Rufus S. Gardner, M.D.</b>  |                                  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |  | 22b. DATE SIGNED<br><b>3/11/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>RUFUS S. GARDNER, M.D.</b>  |                                  |   |   | 22d. ADDRESS<br><b>MEDICAL CENTER, SALISBURY, MD</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Mar. 11, 1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Cambridge, Maryland</b> |   |
| 24. FUNERAL DIRECTOR<br><b>LeCompte Funeral Service, Cambridge, Maryland</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 15 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Judge</b>                         |   |

MEDICAL CERTIFICATION

2250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04436

CERTIFICATE OF DEATH

04437

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Wicomico</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b>   |  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Deer's Head State Hospital</b>  |  | e. STREET ADDRESS<br><b>R.F.D.-#1, XXXXX</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>GEORGE EDWARD WONGUS</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>3 31 67</b>  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>C</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/2/11</b>   |
| 9. AGE (In years last birthday)<br><b>56</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Dorchester County MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John WONGUS</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lizzie CAMPER</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>216-P-1950</b>  |   |
| 17. INFORMANT<br><b>Mrs. Irene Pinder, Vienna, Md., RFD</b>  |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of stomach with wide spread metastases</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr (?)</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 28</b> , 19 <b>67</b> , to <b>March 31</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>March 31</b> , 19 <b>67</b> , and that death occurred at <b>9:45AM</b> , from causes and on the date stated above.                                |  |   |   |
| 22a. SIGNATURE<br><b>Charles H. Winnacott</b>  |  | 22b. DATE SIGNED<br><b>3/31/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles H. Winnacott, M. D.</b>   |  | 22d. ADDRESS<br><b>Deer's Head State Hosp., Salisbury, Md</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>April 13, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cross Roads Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Vienna, Maryland</b>                     |
| 24. FUNERAL DIRECTOR<br><b>Trampten Funeral Home Trubolaby Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 6 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |

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